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"MIND."

By E. Burke Hardin, M. D., Birmingham, Ala.

The study of Anatomy and Physiology may have few features of interest except to those whose line of thought is connected therewith, but for a proper understanding of the complexities that go to make up the individual characteristics of life it is necessary that the mind and its principal organ, the brain be understood. Of the mind, there will be something said later on. The brain is a mass of nervous tissue, located within the skull. It is divided into four parts, viz: the Cerebrum, Cerebellum, the Pons Varolii, and medulla oblongata. It is only the grey matter, mostly located in the Cerebrum, that is of interest to us in the study of mental traits and processes; it is divided into two hemispheres, right and left; each hemisphere is divided into lobes by depressions, called fissures, the fissures are produced by foldings of the gray matter. The lobes are in turn divided into smaller subdivisions by sulci or lesser indentions. Without entering into any of the minutae, by which we would see how the various nerve tissue is connected, how the nerves cross and recross, how the supply of blood is regulated and

the pressure equalized, we will leave all this to the anatomist. It is sufficient to say that the nerves entering and leaving the brain tissue are not unlike the telegraph and telephone wires that enter a large city; each having a distinct work to perform and if interrupted the connection is lost and no work can be accomplished. In the brain of an infant, we might liken it to an uninhabited country, ready for the impressions that form a connecting link between the internal world of mind and the external world. From earliest infancy the brain is receiving impressions and by such a reception, is meant, that the centers are being evolved and becoming educated. The education is in response to its needs; each individual has certain needs in common and in the highest form of society the requirements up to a certain point are fairly constant; it is then a question of the individual, and dependent upon that particular individual's inherited and environing innate desires as to whether he goes beyond these first needs.

By development of the brain, we mean that for some particular action there must be a corresponding cause in the brain; that part of the brain, which by stimulation produces action, we term a center. For example, the center of vision is located in the base of the brain in the occipital lobe; now if this particular portion of the brain is removed or destroyed by disease, vision is lost; if only a certain part of this center is injured, we may have a form of blindness, in which the sight may be present, but the interpretation of objects is impossible. Again by the injury of a certain portion of the temporal lobe, deafness would result; this rule holds true in all the special senses and in many other subjective sensations. These centers are organized material, as is all the rest of the body and are as capable of increase in size or development, and they increase by virtue of the exercise put upon them. As yet only a portion of the brain has been mapped out, but each year is being added to the physiologist's credit some new center. It is not so necessary that they be discovered, as to give credit for those already discovered, for a proper understanding of the central nervous system will aid materially in the uplift of society. In races of the same degree of evolution, it is possible that all brains have the same anatomical out-

lines; the difference being the degree of development of the different centers. In an individual who has the faculty or center of music developed, it follows as a matter of course that there would be a physical difference in that center as compared with one of like kind in another individual who had no such development. Each individual is the result of two dissimilar agents. If it were possible that a being could be created by a process similar to the lower forms of life, from one parent germ, it would no doubt follow the law "that like produces like" but in the creation of a living human being, there are two forces at work, and therefore the offspring must of necessity be unlike either and yet have many of the characteristics of both parents; tho there are apparent variations that can not be accounted for, except as refered to some previous ancestor. The inherent traits are those that come by transmission from the parents, that are influenced by the individual development of the centers of the two parents, and are modified or exaggerated accordingly. The next most important influence in the development is due to the environment of the individual. If a Newton had with all his wonderful inherited tendencies and large brain, ready for the impressions that were to follow, been transported to some savage country, is it likely that his brain would have ever become superior to the savages about him? So that, given a brain with its wonderful expectations and place it in an environment unfavorable, it will likely not become superior to the impressions it will there receive. When we come to realize that each individual is a distinct being, that no other of the same kind exists in the world, that there was present, at its conception conditions that can never occur again; our ideas of the formation of society must be changed; with no two holding the same ideas throughout, follows that no one can be endowed with that mental range capable of catching, even for a moment, a glimpse of the whole field of human endeavor and society. The only way by which an individual can be formed according to a desired plan, is to regulate the two by whose union a new being is formed. It is the opinion of the writer that each being has laid down, at the moment of conception, a destiny as certain as any axiom in science; it has certain individual traits that

are as sure to develop as life lasts; it is born with a musical tendency, a mathematical precocity, a criminal intuition or some one or possibly many well developed centers. It is estimated that over 80 per cent. of criminals inherit the tendency and the only thing that will neutralize the tendency is environment. Nature endeavors to keep her balance true and we see the marriage of the strong with the weak, the lean with the fat, the serious with the gay, the domestic temperament with the literary, the pious with the sinful and so on ad infinitum, in an endless procession. But in spite of nature's effort we constantly see extremes, an over balanced character, a lack of equilibrium; and if this tendency is not corrected, we have produced what is familiarly known as a "crank," while if the tendency is allowed to grow to the exclusion of all else, insanity may result. Environment however is in constant touch with every individual and its impress is laid on each. It is no doubt the intent of nature to create from each acorn a tree as large and as tall as the parent oak, but it depends on its environment entirely, and the conditions that will be forced upon it; the same location as far as nutrition is concerned, the same climatic condition and access to sunlight and the various circumstances that develop from day to day. This holds with the individual; from its conception, it has to contend with environment; there are changes going on in the parent womb differing from day to day; there might be a double conception, in which the division of nutrition has to be made, and it is a fact well known that, seldom are twins alike in their facial or physical conformation. Thus we see that each is a law unto itself, having desires different from others, having hopes and ambitions different from its twin brother; and any iron clad law that endeavors to govern, can only fall down from ineffectiveness. In heredity it is no longer held that disease can be transmitted, but it is thought that a tendency is transmitted; in the scourge of Tuberculosis we see this clearly manifested, in that while the disease is not transmitted per se, there is a tendency, not of the disease so much as a physical type that is most often a subject of the disease, while another peculiar trait is that it has a tendency to appear in the offspring at the same age as in the parent. But if the

fear is entertained in the offspring of tuberculosis, it is one of the most preventable of diseases, by getting into a proper environment and carrying out a few simple rules of hygiene.

If we believed that an individual was conceived in sin and not given the hope of bettering his condition, it would at once make materialists of all. How do we grow better? This is a question that at some time must come to every conscious being. In order to understand it fully we must settle the question, each for himself, what it is in man that is a part of God; it must appear to every one that there is something in him different from the lower animals; what is it? This something is no doubt equally great in all men. It may be a spirit, an essence or what not, but I think it must be the thinking principle of man, or mind. Mind is an intangible thing, God given and is only apparent to humanity through its interpreter the brain. Without the brain it is as tho it were not. Mind is without limit, pervading all the universe, and a man has so much of mind as he has brain to interpret it. That it is immortal there can be no question. It breaks through the darkness in various and unexpected places, through the brains of men, it is not stored in any one place and is not monopolized by any one class; it breaks through, by direct inspiration, the brain of Paul, John or Moses and a host of others; it comes through the lowly Shakespere, Dante and Milton; through the inspired eye of Raphael and Angelo. There must be a cause behind every effect produced, and before a Shakespere could have had such an unlimited knowledge, there must, of necessity, have been at work in his very conception agents of a superior kind; and in some of his less wonderful masterpieces, it may be but the outlet of some depraved inherited centers.

We only get knowledge by study, and by study we are exercising those organs of the mind, which grow in an arithmetical progression. It is a well demonstrated fact that all great brain workers had large brains. The brain has millions of cells by which its mental work is accomplished; just how this work in the cell is done it is not known but it must be in response to some higher power than a material thing, but it is only through the material that the mind is able to make itself

known to the individual. When this relation is disturbed and there is no longer any communication between the mind and the material world so far as that individual is concerned, death has occured. The bodily functions may be carried on but the interpreter is gone. This occurs in various types of injuries where the brain is injured. So that death may be, as some scientist has said, a disturbed relation of the internal with the external. What could this mean but that the principle that ruled supreme over the whole had lost its balance or power of interpretation. The mind works through the cells, and if for example, we have for consideration the center of memory, and it is stored with impressions,—these impressions being but interpretations of the external world by the brain—and the cells are destroyed by disease or dissipation, then we have loss of memory, and the only way in which we will have the same knowledge again is by learning it over and storing the impressions in other cells.

Taking it for granted that the mind is equal in all, we are at once confronted with the fact that all intellects are widely different and can account for it in that the fault lies in the interpreter, the brain. Man is constantly in a state of evolution, as is all inanimate nature. There is no such thing as rest; changes are going on all the time and man is possibly most progressive. It is nature's intention that man move to the highest plane possible and dying leave an offspring that will go higher still, and so on, but heredity and environment come in and instead of progressing, the offspring may drop down in the scale and require a slow process of building up to the point lost.

Thus we see that evolution is playing its part in the world of today as much as in any prehistoric period of the world's history. That there are today races in different stages of evolution, is as patent as any proved fact. And in proportion to their state of development is their brain developed, and according to the anatomical formation of the brain, there is a development of centers. In some of the lower grades of society, an absence of the love of the beautiful, the love of music, the love of reading, indicates that the individuals have not arrived at their full maturity in the process of evolution.

The question might be asked if the brains of Plato, Aristotle, Pythagoras and other great thinkers, were less than the brains of today; I should say no, but they had only a few of the great centers developed and when their reasoning went beyond a certain limit, they showed a weakness. In the evolution of brain and a full development of the centers, the brain has more accurate ability to deal with any question than if only a few of the centers are developed. No center can singly give as accurate information, as several working in union. The act of eating is enhanced to a wonderful degree by the sense of smell added to that of taste; the sense of hearing may be greatly augmented by that of sight; and often we use all together.

As humanity realizes that a law of compensation runs through all their relations, that two agents by a union produce another, that that new being is to be a compound being of all their traits, that heredity is absolute and environment is almost as certain, that mind is regulated by the development of the organ the brain, that each is a law unto itself, that laws governing humanity can only be general and must be elastic, —to cover the derelictions of each—that mankind is a society for all and not that man was created for society, that man must be judged in mildness and with pity, always having in view the influences that enter into him, that mind is God and "as a man thinks, so is he," then possibly we will send men to asylums of education instead of to jails, where crime begets crime, or children to houses of refuge instead of houses of reform, where centers of depravity are educated by contact with others more depraved. It follows that the strong must help the weak or they will never know the remedy that they need. The individual can only assist in his own growth after he has been educated up to a certain point and that point is different in different individuals.

MONEY AND THE DOCTOR.

By Dr. E. H. Sholl, Birmingham, Ala.

A consideration of this subject in detail would consume far more than the allotted time, in fact could properly furnish matter for a small volume. I start out with the proposition that "the laborer is

worthy of his hire." The core and corollary is the equitable adjustment of that hire in accordance with the circumstances and surroundings. Involved in the solution of this problem are the factors time, reputation, skill, ability, and pecuniary resources. It is to be plainly stated at the outset that the question of any fee bill does not enter into this discussion, as no arbitrary law can or should define the conditions and emoluments of service. Given for instance the case of a young practitioner just locating himself the natural query arises as to how he should value his services in the general practice of medicine. My answer would be just in accord with the best practitioners of his locality. Beginning below and estimating his services, he will be rated accordingly and will find it almost impossible in the future in that community, ever to go beyond the minimum with which he has strated and his harvest will be as he has sown. It is always a false conception for any one to minimize his services in the hope of future profit—the law of business does not work in that way. In this connection let it be said that equities necessarily enter. A friend may come to me and say, Dr. "your bill of fifty dollars I consider to be a just and reasonable one and I fully and gratefully appreciate your services, but the fact is with the burden I have upon me, I do not feel able to meet the bill in full, but will be glad to have you make such reasonable deductions as you see proper." You would reply "I am willing under the conditions mentioned to make a deduction not from the daily items of charge but from the bill as a whole and will with pleasure give you a receipt in full for thirty-five dollars." This becomes then a matter of comity and justice into which should enter at all times a proper conception of the relation of doctor and patient, in which while having his own general standard of charges, various occasions may require a deviation from it to meet the surroundings, not to curry favor, for that always sacrifices independence, but to conform to what right and justice seem to demand, the carrying out of the golden rule.

Another important matter and one of justice to the doctor and his family and to his patients is to secure as prompt a settlement of his bills as is possible for the locality in which he is settled. It is always

a mistaken idea to delay the collection of a bill when practicable in the hope of thereby securing a firmer hold on your patient. Unwise indulgence leads to dissatisfaction and almost invariably to a severance of relation with the loss of all or part of the bill. To show from my own personal experience what can be done in the way of collecting in a small town with country surroundings I will state that coming out of the Confederate army as surgeon of Forrest's old cavalry regiment with a dollar and a mule I settled in Gainesville, Ala., a small town on the Tombigbee river and there I remained for the 18 years till I came to this city. Through that whole time which embraced the general period of wreckage that followed the war and the evil times of reconstruction I collected $82.80 out of every $100.00 that went on my books. Horses, mules, cattle, sheep, corn, fodder, oats, hay, wood, shingles, turkeys, ducks, chickens, hogs, butter, cotton seed, clothing, shoes and such other things as were not needed or all such as were convertible into cash or could be utilized to meet current obligations were taken in exchange for professionable services and which gave me for the year 1882 a cash income of more than $2900. In the country where cotton is the staple crop collections as a rule can only be made annually. In those communities where varied crops bring in returns at different seasons collections should be made quarterly. In a commercial and industrial city like this collections should be made monthly through mailed bills, personal collections or collector as may be preferred. For myself I have always preferred to do my own collecting as I can better adjust myself to the peculiar circumstances that may present themselves than the collector who often urges collection when prudence and business kindness would require delay. In many instances where only a single visit is made parties prefer paying at once, which is never refused. When payments are long deferred, which should be made, legal procedure should be invoked and every legitimate effort made to get that which is due. Coming to this city more than 23 years ago and knowing but three or four people, I have followed this rule and while doing a general medical practice and going from alley to palace my collections average annually from 80 to 94 1-2 per cent. of the amount

charged. This is mentioned simply as an illustration of the possibilities and to encourage the younger men of the profession to adopt strict business rules, for the general carrying out of this plan, for what benefits one will benefit all by elevating the general tone and responsibility to the doctor. It is best for all. Few accumulate fortunes, but with judicious economy and the avoidance of debt so far as possible at least a comfortable living and assured social position can be expected. In the medical line of the profession the inequities of proper gradation of charge according to the ability of the party served confronts us, a minimum standard being presupposed. This does not obtain with the surgeon—who like ourselves must often render a service imperatively demanded when there is no hope of pay. A certain fixed rate of charge being understood by the patient it is difficult to convince him no matter what his ability and what the character of the services that he should pay beyond the ordinary charge and in proportion really to the value of the services rendered. I may better illustrate by a case in hand. A physician of this city carried through some weeks of an extremely severe case of typhoid fever, tasking all his resources to bring to a favorable issue, the wife of a gentleman of liberal means. When the bill was sent with an addition of 50 per cent. to the ordinary charges, he declined paying it, having kept tab of the number of visits and for this alone payment was rendered.

The disparity of charge for services rendered between the physician and surgeon is one in which I am not wise enough to see the reconciliation and the outlook, but that it does obtain is patent to all, and so largely that the neophyte just entering upon his profession equips himself and looks forward to the day with eager delight when his revenues shall exceed by far that of the plodding practitioner who toils his weary round from day to day—thankful if in a month he can add to his modest income what the surgeon can realize with the sweep of his knife in an hour. I admit the paraphernalia needed by the surgeon adds to the cost of his work oftentimes much above the requirements of the bedside doctor, but not always so nor for all time, as the outfit being provided only the incidentals come in. I do not wish to be under-

stood as grumbling at this state of facts or disparaging the surgeon, for whose skill when rightly directed I have a profound regard, but to set forth a condition readily recognized by any thinking physician. To my mind the remedy does not now exist and perhaps may not—save in rare instances where generosity bestows an honorarium far beyond the modest claim for services rendered, or where the doctor becomes the paid stipendiary of the multi-millionaire. It does not become a question of greater skill as any careful analysis will show, for the watchful care of the physician in a dangerous and tedious case of typhoid fever must equal any emergency of the surgeon and prolonged far beyond it. The physician for a thirty day case of typhoid fever making his one visit daily, two rarely being needed, will receive at ordinary rates $75 for his services, the surgeon for a case of appendicitis which ordinarily can be discharged in 14 to 20 days will receive from $250 to $1,000. I state these as facts simply, not querously, but as truths from which each one may draw their own deductions. In May, 1886, the first case of appendicitis, then known as pertyphlitis was operated on in the case of a lady patient of mine by Dr. Mortimer H. Jordan assisted by Dr. Wm. H. Johnston and myself. The total fee in this case of the three physicians in this case which resulted in a happy recovery, the lady still living in this city at the age of seventy-four was $100.00. The skilled surgeon of today would laugh at such a fee. The largest fee then known was in the case of a gentleman past seventy operated on for strangulated hernia by Dr. Mortimer H. Jordan assisted by the late Dr. Dozier and myself was $200, and this was then considered a very large perquisite.

My individual impression is that the pendulum has swung too far in the direction of heavy charges for operative procedure except in rare instances where the complexity of the conditions or the great wealth of the patient justifies an unusual fee. Take for instance a case of appendicitis in a family where the means afford a fair average income—to my mind in such a case fee should never exceed $250.00 and might properly often fall below. To the man of large means the charge might justly be proportionate. My plea for this is the cry of the laity who in

operative procedure are often made to bear a burden they cannot cry against, willing to make any sacrifice for their loved ones. This may not reach the ear of the operator, but it is heard all the same and is altogether worthy of consideration. The term appendicitis is simply used as an exemplification of general surgery. Different conclusions from these I have made may and probably will be by others. I am not infallible enough to say that my views must be an absolute criterion or standard for others to go by. I am simply enunciating deductions from my own observation and experience and set them down as such. Whether right or wrong in my views I can readily say that in the ultimate analysis conscience enlightened and apprehensive must be the ultimate arbiter for the action of every right thinking man and its proper finality in the practical application of the Golden Rule "Do unto others as you would have them do unto you."

HEADACHE AND EYESTRAIN.

George M. Gould, M. D., Philadelphia.

That a vast majority of all cases of headache, certainly nine-tenths, are due to eyestrain is a truth beyond question. That with headache, and often without it, a large indefinite proportion of digestional, nervous and psychic disease is due to the same cause is quite as true. A few cases may be due to malfunction or organic disease of other organs, but it is not known in how many of these cases eyestrain is the primary cause of these extraocular diseases; it is also unknown in how many the eyestrain may be the direct and contributing cause of the headache ascribed to the extraocular disease.

PROFESSIONAL NARCOTISM.

In 31 years the members of the American Ophthalmological Society have contributed three papers suggesting that eyestrain is the cause of some headache, and one member has contended that nasal disease, not eyestrain, is the cause of frontal headache. But there have been 122 papers on ocular tumors and many hundreds on ophthalmic surgical

subjects. Medical opinion in continenal Europe has never heard of eyestrain as a cause of anything, much less of extraocular disease, and in England professional pandiculation is confined to a very few "extremists," the mass still dreamlessly sleeping as sweetly as their continental brethren. In our country the testimony as to the role of eyestrain in producing headache is positively overwhelming, but the great body of our medical men are still begging for "just a little more sleep, a little slumber, a little folding of the hands to sleep." As to the ocular origin of much neurasthenia, gastric disease, general ill-health, suicide, etc., we have only got as far as nightmare. What are the results of this professional narcotism?

1. The country practitioners, and some of the silent, modest, general physicians of the cities, are awake to the possible ocular origin of these headaches, etc., but the so-called leaders, the writers of text-books, the members of the professional class, all these, except one or two, are wholly indifferent to the matter. The text-book of Allbutt is described as the best on general medicine in the world. It contains not a word on the subject of the ocular origin of headache, or the ocular origin of any other disease, not even the psychic disease of text-book makers.

2. The general medical profession of America is a hundred times more conscious and acknowledging in the matter than the oculist. It is, of course beneath the dignity of most neurologists to care about the cause or the cure of any disease. While the governor of Massachusetts, in his inaugural address, says that untold numbers of children are becoming ruined in health because of headache, eyestrain, etc., leading members of great ophthalmic societies ridicule such folly. While one great diagnostician says that all sorts of gastric diseases, as is "familiar to all," are often due to eyestrain and cured by glasses, all the stomach specialists in the world and 99/100 of the oculists of the world deny the truth. While a great New York surgeon says he refers a large proportion of his patients threatened with abdominal operation to the oculist, who cures them brilliantly, the entire ophthalmic profession smiles inaudibly at this supposed "extremism."

While the best orthopedic surgeon in Philadelphia publicly states that a large proportion of cases of lateral curvature of the spine are due to eyestrain and ocular function, ophthalmologists are silent or sorrowfully groan and squirm. While medical journals are teeming with reports of the world's greatest scientist as to the sleeping sickness in Africa, the appalling sleeping sickness at home does not at all interest. While from 40 to 60 per cent. of school children, by actual examination, are suffering from headache and other systemic effects of eyestrain, and while great school teachers are trying to get the oculists to stop it, famous ophthalmic specialists are pretending to refract without a mydriatic and with the ophthalmoscope or the ophthalmometer alone, and, of course, the spectacles they prescribe are ludicrous blunders; consequently their pet amusement is to guy the "eyestrain faddist." The professor of medicine in a great university school writes me that, excepting one, he can not make the oculists of his neighborhood believe in the eyestrain origin of diseases demonstrably due to eyestrain.

What is the reason for such a topsy-turvey world? Why are we caught in such a set contraindications and absurdities?

The answers are many, but there is only one that can be emphasized here, and it is absolutely decisive. As general practitioners you desire to cure your patients. Most of you are not professors, mixed up with, and your personalities enslaved by college rivalries, hospital cliques and personal ambitions. You don't care a button for conservatives or extremists, but you desire, first of all, the truth, the knowledge of the causes and the cure of diseases.

NEED OF REFRACTION EXPERTS.

The single explanation of all this wrangling and misunderstanding is that refraction is not a science; your refraction work is not well done. If the experiment could be rightly carried out, of ten or of fifty different prescriptions for the eyestrain of one and the same patient, by as many different oculists of different cities, even in America, not two would probably agree. The test of the eyestrain theory has never been made; no attempt at it has been made. There is no uniformity of

teaching as to the science and art of refraction. If our car axles, dynamos, watches, engine valves and thousands of instruments of precision were made with the lack of precision customary in the diagnosis of refraction errors by the oculists of the world, our civilization would come to smash in 24 hours. If the truth of the eyestrain theorist is to be tested, there is only one pair of lenses which can cure a certain patient. There is not a serious and adequate school of refraction in the world, not an attempt to establish such a school. Until you establish such a school most of your attempts to cure your patients of headache, neurasthenia, disordered nutrition, functional gastric, intestinal and abdominal diseases, many nervous and mental diseases, etc., will generally end in failure.

Wilson, of Montrose, Pa., thus puts his finger on this ailing place:

It is a fact that nearly all the headaches just above and back of the eyes are caused by defective vision, and that large numbers of school children go to their physicians and are given headache remedies without end. This is to no purpose, and they finally have to give up school on account of becoming nervous wrecks, unless by chance they happen into some jewelry store and are given some kind of lenses to wear, which may relieve the trouble to some extent. The country physician should take up refraction work, because the great mass of working people simply can not pay the fee demanded by the oculists and are forced to put up with the indifferent work of the so-called opticians. Two or three hundred dollars will buy the necessary equipment, and a month's work in some eye infirmary will give one a start, and one can do as well at once as any optician will ever be able to do.

As a profession and as specialists we have not raised one finger to prevent or to undo the deep disgrace hinted in these lines. There is not a single adequate, serious school of refraction in the world, nor is there a sign that one is coming. Yet such a school is more needed than all the ophthalmic departments in all the medical colleges and hospitals of the world. If there are a few careful and skilful refractionists in the United States who might agree in their diagnosis of one case, there are 5,000 who would disagree, disagree, root and branch. There are

whole states and territories, whole sections, in which no poor person can possibly get such medical service.

Moreover, there are at the least 15,000,000 American children and adults afflicted with lateral curvative of the spine. All the smiles of incredulity will not, alas, lessen the number, nor the horror of the consequences of the abnormalism. There is no existing machinery, no care or solicitude to prevent the headache and other sufferings, none to prevent the very existence of these millions of scoliotics. The defect arises unknown and unsuspected by physicians and by orthopedists; when it is incurable the orthopedist learns of a few of the cases. Surely over 90 per cent. of these scoliotics owe their tragedies to ocular function and malfunction, readily demonstrable, and its results always preventable. Two months ago, for example, a child of five years of age was brought to me with many complaints, vomiting of food, peevishness, ill-health generally; a nurse and a physician were retained as constant attendants of the child. I found a grade of astigmatism so low that great authorities in this society publicly to the profession and daily to their patients, state that it is useless to correct. Both axes of the astigmatism were at 105 degrees, a defect that produces head tilting and spinal curvature. The child had both. Glasses were applied, and since then the head tilting and the incipient spinal curve have disappeared. There is no vomiting. No drugs are now required. There is steady gain of weight and complete return to normal health. What would have been the life history of this little one had it fallen into the hands of the "ophthalmic surgeon" who scorns the refractionist; who sneers at functional and beginning disease; who does his refraction with the ophthalmoscope, and without a mydriatic; who loves surgery 50 or 500 times as much as he does the prevention of disease; who loves surgery 5,000,000 times as much as he loves the prevention of surgery; who is 40 or 100 times more interested in a sarcoma or an osteoma, or a coloboma, than the headache and vomiting, and "neurasthenias," and suicide of his patients?

Physiologic pathology, not the outworn and senile anatomic variety; functional, not organic disease, clinical, not laboratory and ultrascienti-

fic medicine; individualistic treatment, not that by averages and rules; prevention as well as the cure of disease; such are to be the watchwords of the future.

OCULISTS AND FAKERS.

At present we oculists are most busy and earnest, and effectively so in creating and commissioning "fake" ophthalmic and refraction schools, refracting opticians, peripatetic spectacle peddlers, and quack M. D. oculists. These things are the direct result of our neglect. No blame of course to them who make their chief corner stone the block we have rejected. There are eighty or ninety good reasons why headaches may not be relieved by our prism glasses. At present osteopathy is influencing legislatures, and ignorantly, but far more successfully than many of the profession, it is treating the millions of distorted or weakened and diseased backs and bodies of our people; we neglect the study of the spinal column utterly and wholly in the functional and beginning stages of lateral curvative. Osteopathy is a product of our professional neglect and bigotry, and especially of the ophthalmic variety.

Great surgeons and orthopedists say, if a child does come into their hands with lateral curvature, "O, let it go; give it some exercises; it will get well as it grows older." But spontaneous cure never comes. If they pretend to treat it at all, they give it over to a nurse to handle. In truth they do not treat it until they can treat it surgically; and there was never a case of organic lateral curvature cured, either surgically, or by all the horrible torture chamber machines a Hoffa could devise or picture. Not a man knows the cause of this defect, and how, therefore, can there be a cure? The superintendent of schools of New York City orders his hundreds of thousands to carry their books on one side one-half the time, and on the other side the other half. In this same city great classes of poor children are formed in lines and taught to bend their bodies at command to one side, and then to the other. Better would it be to hold a black cat over the crossroads at midnight and mumble a charm. Osteopathy is a wretched thing, but it often cures and, however, blindly and stupidly it is making some sort

of use of deep massage, the stone which the medical architects refused.

Eddyism is rampant in the land and professionally we are largely responsible for Mrs. Eddy, her foolish children, and her million dollar temples. As medical men we have wholly neglected the attitude of mind of the patient to himself, and to his disease. Especially to her disease! We have been so absorbed in our so-called "science," our professional dignity, our personal reputation and success, that we have forgotten the first duty of any human being: the duty to be kind, and to take a personal interest in each other as individuals, especially if they are our patients. The second duty, also too frequently we have forgotten: to be sincere, to believe in ourselves and our therapeutics. With all the follies of faith cure and of unchristian unscience, the Eddyistic sillies did not forget those two fundamental duties.

Again the quacks have made use of our refused quarryings as corner stones of their healing temples. It is ridiculous bigotry to make fun of the quacks we ourselves allow or create. These quackeries are not made up entirely of errors, follies, greeds, and stupidities. And our medical practices, "scientific" and "ethical" as we fondly imagine them to be, are not without elements and alloys of quackery, folly, and greed.

The more conservative, the more "scientific," the more self-satisfied, the greater, usually, is the alloy of error and quackery. Especially in the cities; especially among the leaders, the professors, the text-book makers; especially among the specialists. The hope of progressive and helpful medicine lies in the general and country practitioners, the modest unknown of the cities, the protestants and extremists. Anything, even earthquakes, are needed to shatter the complacency of the success hunters and of the success getters.

Every text-book, and almost every monograph, and medical journal article will be revolutionized when your oculists agree; your oculists will not agree until you as general practitioners secure the establishment of at least one serious refraction school, with a two-year, or a three-year obligatory course of postgraduate study. And this, as general physicians, is your concern. You will be compelled at last to force us to do our long-neglected duty.

HEADACHES DUE TO AURAL DISEASE.

Philip Hammond, M. D., Aural Surgeon, Massachusetts Charitable Eye and Ear Infirmary; Instructor in Otology, Harvard University, Boston.

Headache to-day, as in the time of Hippocrates, is one of the most common symptoms presenting itself to the practitioner. The modern classification varies somewhat from that laid down by the father of medicine, but, notwithstanding the progress of the ages, many cases continue to be intractable. There are few symptoms whose control affords more relief to the suffering patient.

Among the organs of special sense whose derangement may cause the utmost discomfort to the patient the nasal accessory sinuses and the eye have been prominently mentioned. I add to this list a consideration of certain diseased conditions of the ear, some of them capable of causing not only the most violent headache, but even death.

The ear is generally looked on merely as a means of communication with the world, and its intimate relation with the more vital structures of the head is, in consequence, likely to be overlooked. Then, too, the ear, although exceedingly sensitive in responding to sound impulses, does not betray a slight falling off in function as does the eye. A loss of vision of 50 per cent. could scarcely pass unnoticed, and yet half the hearing power may be lost without the patient being aware of it. Because of this fact it is natural that the attention should have been called first to ocular defects as a cause of headache.

Intimate Connection Between the Innervation of the Ear and the Central Nervous System.—This was early established by Zuckerkandl and later observations have offered further clinical proof of this relationship. In some instances the mere presence of cerumen in the canal has caused most intense headache. Cephalagia is fairly commonly caused by aural disease. It is seldom overlooked in the acute form, because directly referred to the ear. In more chronic cases, as we shall see later, the diagnosis may be more difficult.

Obstruction of the Eustachian Tubes.—Gradle has observed that

children, especially are likely to have an almost continuous headache from slight obstruction of the Eustachian tubes. With this condition the hearing may not necessarily be greatly impaired, and unless one ear be much worse than the other the underlying cause may escape observation. This condition has been termed by Legal cephalalgia pharyngo tympanica. The headache is of a dull, heavy character, and the patient is incapable of sustained work.

Careful inspection of the drum membrane should establish the diagnosis, and complete relief almost immediately follows the simple procedure of inflating the middle ear. This relief is usually temporary, and steps should be taken to remove any adenoids, or other cause of obstruction of the Eustachian tubes.

In the more chronic adhesive processes in the tympanic cavity the subjective symptoms are not always so definitely referred to the ear. Absolute pain is seldom observed with this condition. When found it is generally a referred neuralgia, and its cause must be sought elsewhere. A feeling of fulness in the head, or pressure in the brain, may, however, be associated with the chronic dry catarrh of the ear.

Except in the more advanced stages, the defect in hearing may pass undetected, as the patient may continue to hear the spoken voice to the maximum distance long after distinct pathologic changes have taken place in the ear.

Inflammation of the Middle Ear.—Headache is occasionally caused by acute inflammation of the middle ear, and under these conditions is usually relieved by paracentesis. Politzer believes that some of the most obstinate headaches are caused by a hyperemia transmitted to the scalp. Severe pain in the head accompanying aural disease, not confined to the region of the ear, persisting in spite of treatment, is regarded by Syme as indicating the impending onset of intracranial infection.

For many years we have recognized this to be true of the existence of meningitis, or possibly of brain abscess, and we are now learning that it may be significant of the presence of a sinus thrombosis due to the ear.

It is in the cases of old chronic suppuration, however, that we are most likely to have the more enduring forms of headache. These cases may run their course for years, without any particular symptoms. There may be so little discharge that it is regarded as wax, and the diminished hearing has ceased to annoy the patient, he is so accustomed to it.

Exfoliated epithelium and other products of long-continued suppuration collect in the cavities of the middle ear and mastoid, often forming masses as large as a peach stone. Examination shows that these masses are built up layer by layer, one outside another, until they assume such proportions that they not only fill the unoccupied space inside the temporal bone, but by pressure necrosis actually cause absorption of extensive areas of the bone.

It is apparent even to the casual observer that such a process might reasonably be expected to announce its presence by the existence of more or less pain in the head. This discomfort is usually described by the patient as a dull heavy sensation, but it occasionally assumes a most acute form, when the suffering is almost unendurable. This exacerbation is often caused by the use of fluids in syringing the ear, and particularly by the use of peroxid of hydrogen. Because of the length of time during which this mass, or cholesteatome, has been forming, it is dry and compact. The addition of water almost immediately causes it to swell, with the result that a pressure that is simply tremendous is exerted on all parts with which the mass is in contact. In this way it not infrequently happens that facial paralysis is caused, and occasionally a purulent meningitis may be traced directly to this source.

Caries: These new formations within the temporal bone are not the only cause of headache in chronic purulent otitis media, as this symptom is frequently associated with the presence of caries, especially when accompanied by granulations. It is noticeable that patients undergoing treatment for the relief of chronic suppuration are able to realize the presence of masses of granulations even before the attending physician has discovered them. They will complain that the head feels

heavy and queer, and investigation will usually reveal granular areas. Promptly following the removal of the offending growth, the uncomfortable sensations disappear.

Diagnosis: Diagnosis of the presence of chronic suppuration in the middle ear can often be made by simply noting the presence of discharge, and ascertaining the period of time during which it has existed. In perfectly typical cases, there is likely to be an extremely offensive odor, characteristic of caries. Often, however, there will be little or no visible discharge, and the conditions can be made out only by the most careful examination, using head-mirror, speculum and the other common instruments employed in aural practice. It is an exceedingly common occurrence for an ear that has suppurated at some former time to remain apparently dry for many years, with perhaps a few occasional crusts. In these cases diagnosis is not so easily made, except in the hands of one experienced in such examinations.

Treatment: Treatment should aim toward a complete removal of all diseased tissue. This may sometimes be accomplished by the use of astringent and antiseptic solutions introduced into the ear. When there is distinct caries of the bone, however, the plain surgical indication is for its removal. If confined to the ossicles, they may be easily taken out, and in certain cases not only will the suppuration be cured, but a very useful degree of hearing may be preserved.

In more advanced cases in which the disease has invaded the temporal bone, it may be that nothing short of a complete radical mastoid operation will be curative. In any event cessation of discharge will probably mean relief from headache.

CONSTITUTIONAL HEADACHES.

George L. Walton, M. D., Boston, Mass.

A young woman complains of constant headache of many years' duration. Being asked if it is really continuous she answers, "Certainly, it never leaves me day or night." The headache is not distinctly localized. There is an obvious refractive error, but its correction af-

fords no relief. There is obvious nasal defect, the treatment of which is negative, a possibility Dr. Coakley has emphasized. There is malposition of the uterus, but local treatment proves inefficacious, and the patient returns to the neurologist ready for the next thearpeutic procedure. I assume, of course, that organic disease of the brain, kidney or other organ has been eliminated and that no toxic cause has been discovered. What is the probable diagnosis? Constitutional headache.

This symptom is included among the stigmata of so-called degeneration or, as I prefer to name it, deviation, but its adequate description and pathogeny I do not find. I propose, therefore, to give my own idea of it.

What Constitutional Headache Is.—The patient may show no special physical pecularity except perhaps unusual delicacy or, perhaps more frequently, she presents many signs of deviation from the average normal, either physical, physiologic or mental, or all three. On the physical side we may find a too prominent forehead, a projection of the lower teeth beyond the upper, pegshaped lateral incisors, hair on the face in the female, or absence of hair if the patient be a male, facial asymmetry, and badly formed or badly set ears. On the physiologic side we may find a hypersensitiveness to sights, sounds or thoughts, sometimes associated with an extreme acuity of special sense. Such patient may have vision, for example, double that of the average normal. On the mental side we are peculiarly liable to find deviation. Such a patient is likely to be high-strung, intense, unable to relax either physically or mentally. Strong likes and dislikes are prominent. Even in the course of the examination the tendency will be indicated by the exaggerated self-consciousness; the fussy antagonism, the questioning of each step in the examination, the calling for a fan, or a glass of water, and the request that the window be opened or closed. Certain sources of irritation "simply drive the patient wild;" or she "simply can not bear" something, though the cause may be nothing more serious than hearing another person clear his throat or seeing him rock. The patient herself, meantime, may be obviously addicted to some obsessive habit as grunting, sniffing or blinking, if not to habit

chorea. *Folie du doute,* the touching habit, hypochondriacal ideas and chronic indecision may complete the picture, for which I venture to coin the word obsessia, since all these faulty mental habits may be analyzed into obsessive tendencies. A striking example of this mental peculiarity told me recently that she perfectly abominated cereals, that she simply could not stand vegetables, that she could not bear anything in the shape of an apple, that she could not abide spinach, and that baked beans made her sick at the stomach. The habit movements, the grunting and allied actions are performed by such an individual in response to a feeling that she must make them or explode. The hypochondriacal ideas result from such an obsessive desire to feel comfortable, that any variation from perfect comfort becomes unendurable.

This line of thought prepares us to appreciate the probable nature of the constitutional headache. In its typical form this headache is not perhaps what the average normal individual would call a headache at all. It is merely rather an uncomfortable sensation which is so irksome to the ideo-obsessive, and becomes so aggravated by the focusing of her attention on it that at last only such terms as agonizing, frightful and excruciating seem adequate. In ordinary parlance such a headache should lay the patient low, whereas she sits in the neurologist's office at the end of a long examination perhaps smiling and complacent, explaining her own ability to do so by the fact that she has an extreme degree of will power. She has ample will power, but it is ill directed.

In other words, this headache is probably the patient's interpretation of the ordinary sensations resulting from cerebral activity. The sense of mental fatigue, for example, may be more acutely realized than in the ordinary individual, besides being really excessive, because the mental processes, though ill directed, are kept up more continuously than in the average individual through the patient's inability to mentally relax. This produces the vicious circle. The headache in this case is only another sign of deviation, of which the error of refraction, the congenital nasal or uterine defect are merely other indications.

The Constitutional and the Reflex Headaches.—There is perhaps no sharply dividing line between the constitutional and the purely re-

flex headache. The ticking of a clock may be the exciting cause of insomnia, but the very fact that a clock tick keeps a person awake indicates a sensitive organization on her part which constitutes the underlying cause. Pollen may be the exciting cause of hay fever, of which, however, the primary underlying cause must be the bad constitution of the individual which renders him susceptible. Similarly, when we credit a quarter of a diopter of astigmatism with being the cause of migraine, it would probably be more accurate to say that the error of refraction is the exciting cause, while the primary and underlying cause is the inherited constitution of the patient which renders him susceptible. In other words, between the purely reflex headache on the one hand, and the purely constitutional on the other, there are doubtless a large number of cases in which the two elements are so combined and so interdependent that it is only viewing one side of the shield to class the headache as either purely reflex or purely constitutional.

Treatment.—The treatment of constitutional headache is obviously not hopeful, for its eradication would involve an entire change in the patient's inherent make-up, including susceptibility to fatigue. The correction of obvious ocular, nasal, uterine or other defect is indicated by way of giving the reflex element the benefit of the doubt. Special drugs are of no value, though it is, of course, indicated to build up, as far as possible, the patient's general condition not only by drugs, but by exercise, diet, baths and the regulation of the habits. If by mental training the patient may be led at least to modify the obsessive tendency, a step has been made in the right direction.

CHRONIC HEADACHE ASSOCIATED WITH PELVIC DISEASE.

F. H. Davenport, M. D., Boston.

By chronic headache, as I understand it in this discussion, is meant not a constant headache, but one which recurs at more or less frequent intervals and is of a uniform type. This symptom is not very common in connection with pelvic disease. In taking 1,000 cases from my note book, I find it mentioned 98 times, constituting only about 10 per cent.

In studying these cases and noting the pelvic condition with which the headache is associated, I find the greater part may be placed under two heads. First, those connected, as regards to time, with the menstrual function; second, those which seem to be due not especially to the particular pelvic disorder found in the case, but that seem to be an expression of the neurasthenia of which the pelvic lesion is one of the predisposing factors.

1. *Due to Menstrual Disturbance.*—Taking the first group, I find that 30 cases, or about one-third, are directly associated, as regards time, with menstrual disorders, and the one abnormality which is constant in the cases is a diminution of the amount of blood lost, either from scanty flow with the regular periods, or from delayed menstruation, the interval being more than four weeks, or from both irregular and scanty menstruation combined. In many of these cases menstruation occurred very irregularly, from five weeks to two or three months between the periods.

The most common type of headache found in these cases comes on a few days before the flow occurs, lasting from one day to several, and ceasing promptly as soon as the flow is established. The headache usually precedes the period, but in a few cases in which the flow is fairly regular, but scanty, the headache appears after the period. This type frequently accompanies chronic metritis, when tissue changes have taken place in the uterus and the organ has become cirrhotic. Headaches occurring during the flow are very rare.

The explanation of this form of headache is obvious. There is a hindrance to the normal free and sufficient escape of blood, and as a result a pelvic congestion. This interference with the pelvic circulation shows itself by disturbances elsewhere and the headache is a manifestation of this.

The treatment for this variety of headache consists, first, in general measures to improve the patient's health with the hope that there will be coincidently a change for the better in the rhythm and amount of the menstrual flow. As a rule, these patients are delicate, weak, ane-

mic, and anything which will make them stronger physically is of value. These measures readily suggest themselves and are those which are usually employed in such cases without reference to the particular cause of the trouble or the special form in which the symptoms manifest themselves. The most important are improving the digestion by insisting on as much food as can be assimilated and of a quality which will not tax the digestive organs. Regular and suitable exercise to improve the muscular tone is of great importance. Freedom from mental strain, as study in the case of young girls and social dissipation in those older, should be insisted on.

In other words, measures which will make blood, improve its circulation and steady the nerves will tend to regulate this function. For this purpose drugs are an adjunct, but should not be depended on alone. The most important are iron and manganese, which physiologically tend to improve the quality of the blood. Hand in hand with these general measures and for the relief of the headache itself, local treatment should be employed, and in this way much more direct and quick improvement can be attained. If Nature does not provide relief by a prompt escape of a sufficient amount of blood, local depletion should be employed.

Of the various methods suggested for this purpose there is none which is so simple in its application and so efficient in its results as the use of wool tampons soaked in glycerin. As soon as the slightest suspicion of headache makes its appearance, or even anticipating this by a day or two, such a tampon should be inserted into the vagina and allowed to remain for two days. The result will be a profuse watery discharge of blood serum which relieves the engorged pelvic blood vessels and equalizes the circulation. At the end of the second day the tampon should be removed and a second substituted. These should be applied every second day until the flow appears.

It is not an uncommon occurrence for the patient to experience marked relief within a few hours after the first treatment, and the headache to be kept in check during the whole premenstrual epoch. If repeated before every menstruation for several months, the period

of headache is shortened and in many cases a cure is effected. In the cases in which the headache follows instead of precedes the menstruation, the same treatment should be instituted as soon as the period is over and kept up for several days.

2. *Due to Neurasthenic Condition.*—The second largest group in my series of 98 cases consisted of 23 in which the headache seemed clearly due to neurasthenic condition. They were not associated particularly with the menstrual period, but were brought on by overfatigue, either mental or physical. There was usually, to be sure, some accompanying local pelvic lesion, but that varied indefinitely and did not seem to be the cause. The important question here is as to the propriety or necessity of doing anything for the local difficulty, and my advice is as follows:

Unless there is some weighty reason for not remedying the existing trouble, I usually advise it on the ground that the pelvic disorder, if not the cause, is, at least, a factor in keeping the nervous system below par, and that the patient will improve faster and more surely if this additional source of trouble is removed.

It is not within the scope of this paper to go into a detailed statement of the treatment of these cases. I think that headache is not a common symptom of other pelvic conditions. It was noted in only 14 cases out of 130 retroflexions and versions. There were 13 cases of anteversion, but most of these had at the same time scanty or irregular menstruation, and were probably of a poorly developed type. Some prolapse or enlargement of the ovary was found in 8 cases. Laceration of the cervix was present in 16 cases, and that is significant as emphasizing the fact that lacerations and irritations of the cervix frequently manifest themselves more by reflex disturbances than by local symptoms. In only 4 cases of fibroid tumors and none of ovarian was headache present as a symptom.

CONCLUSIONS.

1. Chronic headache associated with pelvic disease is accidental, except when it is the most marked symptom or irregular or scanty menstruation.

2. In other pelvic disorders, it is usually an expression of the neurasthenic condition of which the pelvic lesion is merely one factor or acessory predisposing cause.

3. Treatment for the first class of cases consists of general building up measures and local depletion.

4. Treatment of the second class consists in the rectification of existing local troubles unless especially contraindicated, but the main reliance is to be placed on prolonged and systematic treatment of the neurasthenia.

DIAGNOSIS OF INSANITY BY THE GENERAL PRACTITIONER AND CONSEQUENT DUTIES WHICH MUST NECESSARILY DEVOLVE UPON HIM.

By C. E. Doherty, M. D., New Westminster, B. C. Medical Superintendent, Public Hospital for Insane.

In general practice a lunacy case will in all probability come under notice in one of the two following ways. First, it may occur in a patient already well known to the practitioner, such a case presenting but a few difficulties to him, as he will have watched and noted the gradual departure from the patient's normal and moral standard, the principle difficulty often being that of convincing the patient's relatives or friends of his or her insanity and of the necessity of prompt removal to a proper place for treatment.

Secondly, the practitioner may be called suddenly to see an absolute stranger, more or less acutely insane, of whose history and antecedents no acount can be obtained, but whose case nevertheless requires to be immediately dealt with; there the difficulty is greater.

A proper recognition of the early and premonitory symptoms of insanity is urgently required, as prompt and judicious treatment will often save the patient from an impending attack. It is usual among the public to picture an attack of insanity as coming on suddenly whereas, in nearly all cases, the onset is gradual. Even in acute mania there is often a short foregoing period of depression.

Although sometimes the early symptoms may be well marked and unmistakable, they are more commonly so light and apparently so trivial that they may pass almost unnoticed by the friends and may even be underrated by the family physician.

On being called to see a patient presumed to be insane, always carry a note book and never his committal paper. The notes you make cannot be too full, in view of possible eventualities, as a mistake on one side may involve the patient's needless removal to an asylum (and I am sorry that we have a few reminders of this annually in our local institutions), on the other hand, a failure to recognize the symptoms may have a dangerous homicidal or suicidal lunatic at large.

If possible, before seeing the patient, have an interview with the nearest relative or friend for the purpose of learning the particulars of the case; obtain from him, if possible, a full history of the case in his own words; inquire into the patient's previous habits and disposition and as to what changes have taken place in these and how recently. Find out whether there have been previous attacks; inquire as to sleep and as to mutterings and imaginary things; go fully over the family history with especial reference to heredity of insanity, drink, epilepsy, suicide, etc.; if the informant be a near blood relative, observe whether he or she is of average intelligence and whether there are evidences of a neurotic tendency.

Your next and more important duty will be to interview the patient. Sometimes this can be arranged with the greatest ease, at others only with difficulty. If he be a general paralytic, a chronic alcoholic or a senile maniac with grandiose ideas, he will welcome the doctor with open arms and will immediately plunge into the subject of his private affairs. But if he be a suspicious melancholic or a sufferer from delusional insanity, it is often difficult to approach him.

I would strongly advise that you insist on being introduced in no other capacity than that of a medical man. The patient is almost sure to detect the deceit sooner or later, unless he be acutely maniacal or hopelessly demented. On being introduced the doctor will have to employ the tact of the man of the world, in order to get on good terms

with him. Having entered the patient's room, the physician will have an eye everywhere. He must observe any peculiarities in dress, whether slovenly or over dressed, fantastic or whether decorated with extra ribbons, extra buttons, etc. He will also note the patient's expression. (this is very important) whether sad, vacant, elated, haughty and arrogant, or tearful and self abased. The expression will usually indicate the trend of his delusions. Observe closely any odd or eccentric gestures, whether he turns suddenly to any part of the room as if listening to voices, or gaze fixedly in any one direction as if seeing something. Mutterings or whisperings will of course be noted. See if the ears are plugged with cotton wool. If so, it will usually come out on inquiry, that this has been done to keep imaginary voices away. I find it is often a good plan, in fact we now make it a general rule at our institution, to make a physical examination of the patient. This may produce no diagnostic results of importance, but it has the tendency to put the patient and the doctor on more friendly terms and opens the door for conversation, during which many subjective symptoms may be exhibited, often accompanied by severe denunciation of supposed persecutors. A question or two as to appetite may elicit hallucinations of taste or delusions of poison. The memory should be tested, both for recent and remote events, which may usually be done by keeping the patient on subjects agreeable to himself. If a patient be talkatively inclined, let him talk on and do not interrupt him. If insane, he is sure to drift to his fancied grievances or ailments. Remember that some patients, especially the educated ones, will often conceal their delusions. Though themselves firmly believing in them, they soon find that others do not and therefore argue with themselves that it is unwise to talk about them, but you will find by carefully handling these in extended conversation it is usually possible to elicit their delusions.

Having once decided in your own mind that your patient is insane, the next and a very important question to be decided is, where he shall be treated, at home, in a public or private institution for the insane. Where you have acute maniacal symptoms and great excitement, this question is usually easily answered, as few families in this country are

in a condition financially or otherwise to care for an acute maniac in their homes. For cases of agitated melancholia, and generally in all cases where there is marked mental or motor excitement, the asylum is by far the best recourse. Cases of stuporous insanity and of acute confusional insanity, without violence, and a large class of cases attended with serious bodily weakness can be treated at home. The same is true, to some extent, with organic dementia, a small percentage of paresis and some cases of epileptic insanity. The inconveniences, however, especially in organic and paretic insanities, are very great and home treatment should hardly be advised unless the best nursing facilities are available.

In cases of paranoia with delusions of persecution, it is certainly advisable that the patient be sequestrated and placed where he can do no possible harm. There are many of these monomaniacs at large who ought to be under restraint, but the public, and especially their friends, often do not realize this until some tragedy has occurred.

There is still another point in connection with your decision, which always should be borne in mind when discussing the home treatment of the insane, and that is the influence of the insane upon other members of the family. The effect of an insane member of the family living in close relation with the rest, who are themselves somewhat predisposed and some of whom are of an impressible and receptive age, subject to the various influences that may affect them, is not in itself a desirable one and might in some cases be disastrous. This appears to me to be a consideration worthy of attention on the part of the physician, when the question of home treatment is left to his decision.

As the matter of establishing wards in general hospitals or a separate institution for the reception of acute cases of insanity has been considerably discussed at previous meeting of this Association and has been strongly advocated, especially by one member of the profession who has given considerable attention in his private practice to the subject of insanity and its treatment, a few words relating to such institutions might not be out of place.

An acute hospital would possess no advantages over the acute ward of our Provincial Hospital for the Insane, when it would have a great

many disadvantages. Among others would be the following: The duration of the acute symptoms is very variable and on its termination there is another variable period, between the cessation of the acute symptoms and convalescence. What is to be done with the patient in this stage? Is he to be compelled to associate with the acute cases or is he to be transferred to the Provincial Asylum? It is possible that in a hospital for acute cases only, each patient might receive more individual attention than in the large wards of an ordinary asylum, where from twenty-five to thirty-five patients are under the care of three nurses, but it must be remembered that of these patients, not more than two or three are acute cases such as require the constant attention spoken of.

I firmly believe that in well managed asylums, under the present system, patients obtain all the care, treatment and attention they require and this belief would seem to be justified by the fact that in public institutions an enormous majority of the acute cases recover. Further, in many acute cases, it is an undoubted advantage for the patients to mix with those who have settled down and made themselves at home. It is also advantageous to have only two or three acute cases in each ward and, except in very large asylums, the number is rarely exceeded.

In contrast to this, imagine the state of things in an acute hospital, where all the acute maniacs and melancholics of the district are collected and where no order could be maintained. It might be urged that this system of mixing the cases is not quite so pleasant for the convalescent and quiter patients, but the trials arising out of it which these patients are called upon to bear are very slight in well managed asylums, while the exercise of sympathy and forbearance, as also the diversion of their attention from themselves, may often be highly beneficial to them.

I feel certain that the question of experienced nursing would also be a great drawback to the treatment of acute cases of insanity in general hospitals for it is absurd to imagine for one moment that such cases can be properly treated by persons with no special knowledge of, or experience in, all the details of the moral control these patients require and

it is our duty, as asylum physicians, to voice our condemnation of any attempt to minimize this, by far the most vital part of their treatment. Further, the periodical visits of a consultant are practically useless as regards the supervision of details which are of daily, even hourly importance for the care of the patient. It appears to me that it would be a great mistake to give acute cases, the most difficult of all to manage, into the care of hospital nurses, with no asylum training, who do not know what to do with them, who cannot understand the constant supervision and the unceasing vigilance they require, who are unable to anticipate a suicidal impulse or an outbreak of homicidal violence and who will either rush in terror from the room at an outbreak of excitement or will resort to injudicious and unnecessary use of mechanical restraint. I am speaking of things of which I have a personal knowledge and such occurrences are very frequently brought most forcibly to our notice. Patients, very often females, arrive at our hospital in charge of nurses and policemen and, much to our disgust, it is not uncommon to see these unfortunates shackled and handcuffed. These nurses upon being relieved of their patient, will heave a sigh of relief and will immediately proceed to give a most graphic description of the patient's action and dangerous propensities, generally accompanied with an account of several hair-breadth escapes on their own part.

Such experiences as these, coupled with the history of their handling of the case, firmly impresses upon my mind that the public institution is the place for all insane, with the very few exceptions already mentioned, and if any effort is to be made in the interest of the insane, let it be in the shape of increasing the general comforts, amusements and the scientific treatment in our public institutions. I would further like to state to the profession of this Province, that, as a result of a recent visit to the eastern institutions, I can safely say that our hospital for the insane compares favorably in every respect with other institutions in the Dominion and, in fact, I do not think there is another in the Dominion, where pauper patients receive the comforts that they do in this Province.—Northwest Medicine, September, 1906.

PROLAPSED OVARIES.

By William S. Gardner, M. D.

"Doctor, do you see many cases of prolapsed ovaries?"

"Lots of them.

"What do you do for them?"

"God knows."

This was the beginning of a conversation that I had recently with a well-known gynecologist of this city, and illustrates only too clearly the attitude of many of the profession toward this condition.

In the development of gynecology, the removal of large fibromyomata, the wide dissection to remove carcinoma and the wandering away after things in the upper abdomen has consumed so much time and work that the small but discomfort-producing prolapsed ovary has been overlooked. And its neglect has left many patients in needless pain and brought discredit upon the attending surgeons.

A brief outline of the history of one case can be used as an illustration of quite a large class.

(574) E. W. aged 16 years, was admitted to the City Hospital early in October, 1905. She was first in the care of the internal medicine department, where a careful history and complete physical examination revealed no pathological lesion. She was transferred to the gynecological side October 17. She had never been pregnant. She began to menstruate at 13 years of age, and the periods have recurred regularly, with a duration of from three to five days, and always painful. The pain precedes the flow about one week and continues for one week after the flow. The pain is in both sides of the pelvis and in the back, and there is severe occipital headache.

Since June the attacks of pain have come on independent of the flow every two weeks. During some of these attacks of pain she has violent hysterical convulsions lasting from 10 to 20 minutes, and which leave her very weak. The convulsions are always preceded by the pain, so that she is able to know when they are coming on.

A bimanual examination under anesthesia was made and a retrovert-

ed uterus with both ovaries in the cul-de-sac were found. The patient was quite anemic, but no other gross lesion than the one mentioned was detected.

The abdomen was opened, the ovarian ligaments shortened, bringing the ovaries up close to the posterior side of the uterus just behind the region of the Fallopian tube one either side and a Gilliam's suspension was done.

The post-operative history is uneventful. She called upon me August, 1906, and states that she is getting along well and has had no return of the nervous attacks, and is free from pain.

Causes.—A very large proportion of prolapsed ovaries occur in association with retrodisplacements of the uterus, and when we take into consideration the frequency of retrodisplacements and the fact that about 25 per cent. of all of them are congenital, one of the most prolific causes of prolapsed ovaries is accounted for. Another condition found is that nearly all prolapsed ovaries are enlarged. We are compelled to consider whether the enlargement is a cause or a result of the prolapse. There is no doubt that in part of the cases the enlargement comes first and is the direct cause of the prolapse, the suspensory lingament becoming elongated by the constant dragging.

On the other hand, the enlargement is so constant that there must be some direct relation between the increase in size and the increased congestion resulting from the displacement. The enlargement in some cases is an actual increase in ovarian tissue; in many the enlargement is due to a septic condition.

The direct cause of the prolapses in the cases of those associated with retrodisplacements, and more particularly in those in which the uterus retains a normal position, is the elongation of the ovarian ligament, which should hold the ovary fairly close to the fundus of the uterus.

Symptoms.—These patients present a series of symptoms which occur with a sufficient degree of regularity and frequency to present a fairly clean-cut clinical picture.

Pain in the pelvis is one of the most constant complaints. Very commonly it is located in both ovarian regions, and in some instances in one side only. At times it radiates down one or both legs and is in-

variably increased by the patient being on her feet. This pain is sometimes so severe that the patient cannot be in the erect position except for short periods, and then with great discomfort.

Pain in the region of the sacrum which seems to extend upwards and is associated with a severe occipital headache is very common. The pain in the back is constant while the occipital headache is paroxysmal, and is usually exaggerated at the menstrual periods.

A very characteristic symptom of prolapsed ovaries which I have not observed with any other pelvic lesion is a severe paroxysmal intermenstrual pain in the pelvis. This pain comes on from two to fourteen days before or after the periods, varying in different cases, but usually very constant in its relation in time to the period for each case.

The dysmenorrhea from which these patients suffer is usually severe. In nullipara it frequently dates from the beginning of menstruation. In those who have borne children the pain usually dates from some time subsequent to the last labor, and usually from a date, corresponding with the beginning of the pelvic pain and pain in the back. The pain as a rule begins before the flow, continues through the period and for a day or more after the flow has ceased.

The nervous symptoms from which many of these patients suffer are of such a character that the patients are not infrequently classed as hysterical or neurasthenic. This is not correct, but the tendency of many of these patients is to be easily excited; to cry without provocation; to laugh immoderately; to be easily irritated; and to be in a generally unstable mental condition is very common. Occasionally one will go so far as to have convulsions, which are classed as hysterical convulsions. The convulsions have a tendency to recur at the menstrual period.

One patient complained of nausea whenever she was on her feet for a short time. Painful coition is one of the best-known symptoms produced by prolapsed ovaries, and needs very little comment. It is of value, however, in only a limited number of cases.

Painful defecation is also a common symptom. In some cases the pain comes on during the act of defecation, and in some the pain comes

just after the bowel is emptied and continues for some minutes.

It will be noted that many of these symptoms correspond very closely to those usually ascribed to retrodisplacements of the uterus. While at this time I do not feel justified in stating it dogmatically, I am reasonably satisfied that many patients with retrodisplacements are suffering more from the associated prolapsed ovaries than from the uterine lesion.

Diagnosis.—The diagnosis is usually made without difficulty. The prolapsed ovary can be felt quite easily in the cul-desac directly behind the uterus or can be caught between the fingers in the vagina and the pelvic wall. It can be recognized by its tenderness on slight pressure, by its shape and by its tendency to slip away from the point of pressure.

Treatment.—Before the operative era the treatment of prolapsed ovaries was the use of vaginal tampons and pessories. The practically unanimous opinion was that very little at best and usually nothing was accomplished. Afterwards came the time of the removal of good, bad and indifferent ovaries. The prolapsed ovary gave rise to much discomfort, and without reference to its being diseased or not, it was removed along with others.

Conservative surgery, which I understand to mean the removal of only hopelessly diseased organs and the preservation of everything consistent with the restoration of the patient to health, makes the removal of prolapsed ovaries look like the bad surgery which it is.

Quite a number of the more recent text-books recommend the suspension of a prolapsed ovary by shortening the infundibulo-pelvic ligament, or by stitching the ovary to the peritoneum at the brim of the pelvis. But apparently very little attention has been paid to the subject. The only recent article in English that I have been able to find is one by Barraus in the Medical Record, N. Y., 1904, vol. lxvi. He reports 12 cases in which he successfully treated the condition by making an opening in the broad ligament, bringing the prolapsed ovary through and fastening it on the anterior surface of the ligament.

The operation that I have been doing for more than a year now

is, I believe, simpler and more correct from an anatomical point than either of the above operations. It consists of shortening the elongated ovarian ligament by a couple of fine silk stitches. The first one takes a light but firm hold in the uterus near the lower border of the ovarian ligament; it is then continued through a portion of the ligament and inserted firmly into the ligament near the ovary. The second stitch is placed in the same way, but near the upper border of the ligament. When these stitches are tied the ovary is brought close up to the uterus, but still retains a limited mobility independent of the uterus, and a complete mobility with the uterus.

As many prolapsed ovaries are associated with retrodisplacements, after the ovaries are fixed to arteries the operator can proceed to do the operation of choice for the correction of the displacement. I feel quite sure that the failure to properly suspend the ovaries is frequently the cause of the failure to relieve the symptoms when suspension of the uterus to correct retrodisplacements is done.

HEMATURIA.

J. W. Bennett, M. D. Brookhaven.

The first case I have chosen to present has been diagnosed hematuria, unqualified. The patient is a white woman, forty years of age, the mother of seven children, all healthy, and she herself has been uniformly healthy and of fair complexion, inclined to ruddy. She suffered one former attack, some ten years ago, which lasted three or four months, but did not prostrate or weaken her much, which signifies that the hemorrhage was not profuse.

The patient at the present time, after six weeks duration of hematuria, presents moderate emaciation and a pallid complexion which has varied at times during the protracted spell and the varied treatment. I might as well remark as I go along that hematuria *per se* has no pathology, being but a symptom of a disease which is of first importance to the physician to determine as he begins his treatment, which it is *sometimes* very easy to do.

A short definition of hematuria may be put down as blood in the

urine, and this gives a wide range in deciding as to causes. One might begin with tramatism of the kidneys, and follow the course of the ureters and urinary tract, including the bladder, and all the diseases of each.

Among kidney causes may be included turpentine, cubebs, copaiba, cantharides, etc. Some causes have their seat in the ureters, as cancer, polypi, ulcers, calculi, etc., but the general causes of hematuria are acute infectious diseases—fevers especially—and more especially malarial fever. The case I am now presenting appears to me to come under this head—though not well defined—not because the malarial symptoms to me are so plainly marked, but because all the other sources which I have enumerated are absent. This patient had never in her life had many attacks of chills and fever. During the present hematuria I have frequently observed temperature accurately and always found it between 98 and 99 F. No perceptible chills, no sweating, no nausea. However quinine has had more marked influence on the hematuria than anything else tried. Among other remedies tried I may mention astringents, as tannic acid and decoctions of the leaves of the uva ursi. The last she drank freely for a time and was charmed with the effects, which I think were due mainly to the tannin in it.

The next case I will present is that of an irregular house carpenter. A man about forty years of age, very temperate as to physical exercise, though he would indulge once in a while and work at his trade, and two years in succession I have known him, after working a week or so, to take chills and then have an unmistakable hematuria, very marked at the chill hour. Quinine soon relieved him, coupled with abstinence from labor.

But the true type of malarial hematuria comes more generally after or along with chronic malaria. I will only report two other cases which were strongly impressed on my mind.

They were in the persons of two little white boys of nearly the same age and the first pet sons of young mothers. They were transient little fellows, sometimes in Brookhaven, sometimes in Jackson and sometimes in Monticello, though one of them lived more constantly in the

Bogue Chitto swamp. Consequently they came under different physisians and sometimes under none at all. I remember very distinctly, when I would try to present something, how emphatically the young mother would tell me, in the presence of her son, the futility of mentioning quinine or anything of its kind. They both lingered along in this manner two or three years before the hematuria marked—the patient already pale and bloated. Only a few attacks followed after this. The stomach of the one I saw would not tolerate medicine of any kind, except minute doses of calomel. I have thought perhaps both of these little fellows might have been saved had they had early treatment, persistently carried on, by a hypodermic use of quinine without any trust to mothers to administer anything. This with a change of climate might have saved them from the hematuria by curing the malarial fever and the change of climate would have assured it.

BREAKFAST FOODS.

No provision of the pure food law affects the cereals, nor will the output be diminished by the passage of the law.

The very extensive use of cereal preparations in the last decade or two in America has been greatly stimulated by the advertisements of the manufacturers of the so-called "breakfast foods" or "prepared cereals."

The claims of the manufacturers that their preparations are more wholesome, nutritious and easily digested are based on the plea that special processes of milling, cooking, crushing and so on have been introduced. These claims are so plausibly worded that the average person is inclined to believe that their values as muscle and brain builders are really considerably increased by the processes used in their manufacture.

Dr. Bartley, Professor of Chemistry at the Long Island College Hospital, has investigated nearly one hundred samples of prepared cereals, with a view to determine what food value the manufactured or prepared cereals have.

The full results of his investigation will probably soon be published,

but he has allowed us to make use of his investigations and to give his conclusions.

The cereal breakfast foods sold in packages contain, in almost every case, as much food value, weight for weight, as the cereals of which they are composed. Their ingredients are wheat, corn, oats, barley and rice, respectively, or they are mixtures in varying proportions of two or more of these. No preservative or adulterant is contained in any of the cereals so far as investigation shows. Some of the cooked or semi-cooked and crushed or rolled prepared foods require less cooking than the unprepared grains, but these on the other hand are more subject to fermentation or "souring." He believes he has traced to this source some of the eruptions in children.

As a rule the unprepared oatmeals and other cereals and most of the prepared cereals reach the table insufficiently cooked. Many of them should preferably be cooked or, at least, soaked in water over night, when intended for serving on the following morning.

The only possible advantage of the prepared cereals over those bought in bulk is that some may require less cooking, while at the same time they are more subject to the attacks of fermentation-bacteria.

In process of preparation or manufacture, their bulk, as a rule, is very greatly increased, thus bringing the cost, bulk for bulk, very much higher in the case of the prepared article.

The "ready-cooked" cereals have largely displaced the older broken-grained cereals, but many of the former are found to be insufficiently cooked—the cellulose envelopes containing the starch granules unbroken —while in those in which this envelope is disintergrated by cooking or bruising there is a likelihood of early decomposition of the starchy ingredients.

The possible advantages of the prepared article are, novelty and apparent variety, and less necessity of prolonged cooking. In the case of the old style, cracked grain cereals, there is greater resistance to degenerative changes if stored for any length of time before use and a very considerable saving in the cost of a staple article of food, which, if properly prepared, ranks high in relative food value.

Editorial.

COLLABORATORS:

T. W. Ayers, M. D., Hwang-hien, via Chefoo, China.
J. T. Searcy, M. D., Tuscaloosa
L. C. Morris, M. D., Birmingham.
J. A. Goggans, M. D., Alexander City.
W. W. Harper, M. D., Selma
Frank T. Smith, M.D., Chattanooga, Tenn.
E. D. Bondurant, M. D., Mobile
B. L. Wyman, M. D., Birmingham
Thomas D. Parke, M. D., Birmingham, Ala.
W. H. Wilder, M. D., Birmingham,
D. F. Talley, M. D., Birmingham.

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Some Things May be Seen With the Naked Eye.

If any of us have had an opportunity of observing an expert woodman at work we have certainly had cause to marvel at the almost superhuman vision of which he seemed possessed—at the wonderful accuracy with which he interprets the signs of the wood.

We may follow after, but our unseeing eyes are blind to the history

of the trail—to incidents that he sees at a glance. Could not we of the medical world learn a valuable lesson from our so-called ignorant brothers of the wood and field?

Acute educated eyes that read beneath the surface—delicate hearing that differentiates—fingers that think—are as necessary to the truly great doctor today as they were before the invention of the microscope, the stethoscope or the blood pressure machine. It is, perhaps, a little old-fashioned now-a-days to trust your senses unaided to the extent of making a diagnosis, to the point of following out any definite line of treatment. We may glance at our patient's face, his tongue, and even examine his throat, but we are not very much concerned over what we see or do not see—for there is always a specimen of blood to be examined, which will presumably make all clear.

We must put on our glasses and then listen for something with the stethoscope, or examine something with a microscope before we believe that there is any field for either observation or thought. Figuratively, we array ourselves in the armament of crutches, each decaying sense being propped by its own particular crutch—and then we are ready for true impressions. We are going to throw the responsibility of a diagnosis on the absence or presence of a little germ that we know no human eye could see unaided, and we are going to reserve the use of our eyes for their search.

Is not this carrying scientific caution a little too far? Are we not in our interest and enthusiasm for the world the microscope has given us, in danger of under-rating the importance of that world belonging to the eye unaided?

Are we not becoming a little careless in the use of our senses directly —that is unaided—for this reason are we not in danger of becoming blunted, blinded to impressions that should be ours? Every means toward the formation of correct impressions toward the development of

a true concept as to the state of our patient is too valuable to be slurred or forgotten. And for this reason we should cultivate eye, hand and ear to the best capabilities and enhance our own usefulness thereby.

In Memoriam.

Dr. Malvern N. Due was born in Wetumpka, Ala., Oct. 20, 1862, and died Oct. 17, 1906.

Dr. Due from early life had all the advantage of such surroundings as were helpful. Educated in New Orleans by Paul Tulane from his earliest years to the time of his entrance in Princeton University to his graduation from that institution in 1885, nothing was lacking for the broadest opportunities for culture, refinement and scholarship.

How well he embraced these opportunities those who have known him since his entrance on the profession here can testify. He was a graduate of the College of Physicians and Surgeons, N. Y., 1888, and was licensed the same year by the County Board of Montgomery. From that time till health failed he was actively engaged in his professional work in which he acquired the reputation of a cautious, safe and intelligent practitioner fully up in his work to the most modern methods in the general practice of medicine. His gentlemanly unassuming bearing, with his strict attention to his duties, won for him a clientele that believed in him and trusted in him, knowing his careful investigation of all the ailments that came under his care.

Modest and retiring in his disposition and handicapped to some extent by his deficient hearing, his work was a growing one till the infirmities of disease put an end to his labors. In the epidemic of smallpox in 1897 when the community was almost in a panic, his executive labors in searching out cases, removing them and compelling vaccination as he acted under the County Board of Health were of great practical value to the city at a time when an imperative necessity demanded strenuous efforts often times to compel the evaders of the law to comply with its requirements. He was strictly ethical in his obligations to his fellow practitioners and was mindful of the pledge he

assumed when he connected himself with this society and had clear-cut, honest ideas of what those duties were and fulfilled them, believing that the requirement was a binding one. Loyal to his society and his associates in the practice of medicine he will be missed by those who knew best and loved him as their physician and friend. The milestones in life are marked by the graves of our friends.

So be my passing—
My task accomplished and the long day gone—
My wages taken and in my heart some late lark singing,
May I be gathered to the quiet west—
The sundown splendid and serene—
Death.

Resolved that a copy of this memorial be sent by our secretary to the family of our deceased brother and entered upon our records.

E. H. Sholl, M. D.
J. W. Barclay, M. D.
E. T. Glass, M. D.

Oct. 3, 1906, for Nov. 12, 1906.

PATHOGENESIS AND PROPHYLAXIS OF MALARIA.

Kelsch does not deny the mosquito theory of the transmission of malarial infection, but he believes that this does not exhaust all the possibilities of transmission of the infection. Experience has too often demonstrated that epidemics of malaria follow extensive turning up of the soil and excessively hot seasons, ingestion of dust-laden food, over exertion, and other faults against hygiene. The distribution of the anopheles, also, does not always correspond to the distribution of malarial foci, and there can be no doubt that the hematozoon finds other ways of access to the body than in mosquito bites. In all his experience with malaria in France he has never known of an instance of the direct transmission of malaria from man to man. Malaria is very prevalent in Madagascar at present, and he ascribes the epidemic to the extensive sanitary works now under way there.

Miscellaneous Notes.

A baby recently born on the lower East Side, New York, is said to have weighed 22 pounds at birth. It was the fifth child of its parents. The previous children are said to have weighed, in the order of their seniority, 10, 15, 16 and 18 pounds. Such a history ought to counsel prudence to the most ambitious parents.

According to the New York Sun, an experiment in the simple life undertaken by a group of German authors, philosophers and painters came to a speedy and sad conclusion. They wished to live in primitive fashion, without clothing, subsisting on roots and fruits, and employed only in tilling the soil and tending herds, on the Island of Kabakon in the Bismark Archipelago. Two of the colony died from the effects of insufficient food and clothing, the native islanders killed another colonist and the remainder returned to civilization.

The Cattle Commission of Vermont is charged with gross neglect of duty in connection with the disposal of diseased cattle. The law requires the bodies of condemned animals to be buried, but the Commission is said to have sold such carcasses for the manufacture of fertilizer. This does not seem a very heinous abuse of their powers, provided the proceeds of such sales were honestly accounted for. But it is also charged that a member of the Commission sold 200 condemned cows to a drover, who took them over into Massachusetts, where all but 20 of the animals were slaughtered and sold as food.

The Tri-State Chess Association, an association of over 400 players, most of whom reside in the Mississippi valley, is arranging a correspondence match at chess, the Doctors vs. the Laity. It is desired to have physicians from every section of the U. S. engage in this match. Therefore, every chess-loving physician is urged to become a consultant in the case. The match will begin early in November; entries accept-

ed until January 1. All who will play are urged to send name and address to the president, stating the number of games they will take on. There is no fee attached to the match. Address Dr. Van Nuys, president, Lorain, Ohio.

The College of Physicians of Philadelphia announces that the next award of the Alvarenga prize, being the income for one year (about $180.) of the bequest of the late Senor Alvaranga, will be made on July 14, 1907, provided that an essay deemed worthy of the prize shall have been offered. Essays may be on any subject in medicine, but cannot have been published. They must be typewritten, and must be received by Dr. Thomas R. Nelson, secretary of the college, on or before May 1, 1907. Each essay must be sent without signature, but marked with a motto and accompanied by a sealed envelope having on its outside the motto of the paper and within the name and address of the author.

In Virginia the State Medical Society makes recommendations to the Governor concerning appointments to the State Board of Health, and in some localities the same right is conferred by law on the local medical societies. If there were no law on the subject the medical profession might undoubtedly exercise a wholesome influence in such matters, but being charged by law with such functions the profession has but little success to its credit. Recently the Norfolk Medical Society had the opportunity to nominate a health commissioner for the city. The Society refused to recommend anyone, declaring that any member of the Society is competent to discharge the duties of the office. This action indicates the high-water mark of opulence in professional skill of a very special character.

CEREBRAL TUMOR.

Mercier reports one case which was improved somewhat under ordinary remedies, but was cured finally by a sudden severe shock caused by the elopement of the patient's daughter.

TABES DORSALIS IN A NEGRESS.

The rarity of this disease in colored women leads W. G. Bowers to report a typical case occurring in a negro woman. He has been able to find twenty-one reported cases in this race, fifteen men and six women. The history presents no peculiar features. The patient was a woman of fifty-three, with symptoms dating back three years. She was in the hospital three and a half months and finally died from cystitis and sepsis following bed-sores.

AGORAPHOBIA.

In the case reported by Macewen two granulomata, probably syphilitic, were removed from the left motor area of the brain, involving principally the leg and arm centers. Seven weeks after the operation the patient was in good health, and was bright and intelligent, although he sometimes found difficulty in expressing himself, particularly when excited. The right arm and leg were still deficient in power. The patient had no more fits after the operation.

AN UNUSUAL CASE OF TIC.

Alfred Gordon reports this case. The patient, a man twenty years old, exhibited peculiar forward movements of the trunk. These movements consisted of abrupt, spasmodic, and repeated bending forward of the upper half of the body over the lower. The contraction was found to be limited to both recti muscles. The tic was exclusively abdominal and in the domain of the recti muscles. No other part of the body was involved. The treatment suggested was chiefly psychic.

TREATMENT OF CANCER OF THE BREAST.

Beverly MacMonagle presents these conclusions: All tumors of the breast are a threat to the well-being of the patient. Positive diagnosis cannot be made in the early stages without microscopic aid. All tumors of the breast should be removed with care to prevent reinoculation. Microscopic diagnosis should be made. This should be followed at once by raidcal operation if the growth is found to be malignant. This method gives the best chance of improving the results of surgical treatment of cancer of the breast.

PATHOLOGY OF CHOREA.

Poynton and Holmes report 3 additional cases in which a diplococcus was found in the pia mater in cases of chorea that proved fatal. In addition, this organism was demonstrated in the brains in these cases lying in the perivascular spaces and connective tissue. As the result of their study the authors conclude that chorea is a manifestation of acute rheumatism, and that the demonstration of diplococci in each of the three cases is a striking confirmation of the assertion that the *Diplococcus rheumaticus* is the infective agent in acute rheumatism.

TREATMENT OF PNEUMONIA.

Woodbridge Hall Birchmore declares that after the intestinal tract is emptied and cleansed and carefully maintained in satisfactory condition, nutrition will not be seriously interfered with. The body can then supply the needed strength for the healing process. To combat the cough ammonium chloride and the mixtures of the bromides have been found of the utmost use. The control of the circulation is best accomplished by the combined use of aconitine and digitaline. The latter causes contraction of the pulmonary arteries, while the former relaxes the systemic blood,vessels. If there is insomnia the writer believes that hyoscine is the best hypnotic.

INFLUENCE OF REST, EXERCISE, AND SLEEP ON GASTRIC DIGESTION.

Julius Friendwald, from his observations draws the following conclusions: In persons with normal digestive powers it makes but little difference whether the individuals rest, exercise, or sleep after meals, though after violent exercise or sleep the gastric digestion is very slightly impaired. In patients suffering with superacidity and subacidity it is best to order rest after meals; after violent exercise or during sleep the digestion is impaired in these cases. In patients suffering with motor disturbances of the stomach it is best to prescribe moderate exercise after meals, for rest, violent exercise, or sleep disturbs the digestion under these conditions.

EXTERNAL EYE INFLAMMATION OF DOUBTFUL ORIGIN.

Two cases are recorded by H. G. Langworthy. In the first case a young man of twenty-six suffered from a bilateral orbital cellulitis and exophthalmos simulating cavernous sinus thrombosis and double frontal involvement. The infecting organism was probably the pneumococcus. In the second case a young man of eighteen was the subject of acute bilateral edema of the eyelids of unknown origin. The diagnosis seemed to lie between angioneurotic edema and inflammation of both frontal sinuses. Both patients recovered. The author appends a bibliography of similar cases.

SCARLET FEVER.

Joseph F. Chmelicek Luhan in the last five years has not lost a patient with scarlet fever, nor among his 129 patients has there been a serious complication. He believes that the condition of the blood is the direct cause of cardiac paralysis, to which death is due in so many cases of this disease, especially in children. He isolates the patient in the lightest and best room in the house. A warm bath is given and the bowels are relieved by an enema or magnesium citrate. The patient is kept on a strict diet of milk, with plenty of water and soups. Antipyretics, excepting the tepid bath, are not used. Elixir of sulphocarbolate of iron is prescribed up to the fourth day; after this, elixir sulphocitrate of iron is administered for four days.

THE ROUTINE TREATMENT OF SYPHILIS WITH INTRAMUSCULAR INJECTIONS OF MERCURY SALICYLATE.

In this paper W. H. Palmer covers familiar ground. Nothing especially is brought forward. He discusses the question under the headings of advantages of the salicylate over other mercurial salts, the advantages of this method over other methods, the disadvantages of the salicylate, changes produced in the tissues at the site of injection, the preferable injection site, the suspension fluid, the question of sterilization of the solution before injection (which he does not consider absolutely necessary), syringe and needles and their proper care, tech-

nique, dosage, and duration of treatment. He refers to an interesting case reported by Kalisch who met with a gumma which occurred at the point where an injection had been given five years previously. The gumma was incised and microscopical examination showed a minute amount of unabsorbed mercury which had probably acted as a local irritant, and in this way had determined the development of a gummatous lesion in this situation.

THE NEGRO BRAIN.

There is little doubt that the race feeling which is present in those states which contain a large negro population is due to the fundamental differences of a psychologic and temperamental character between the two peoples. It is interesting, therefore, to find in Bean's recent paper the evidence that there are anatomic differences in the brain of the negro which distinguish it from the brain of the Caucasian, and which doubtless account for the differences in mental character which distinguish the two races. The negro brain is smaller than the brain of the Caucasian, especially so far as the frontal lobes are concerned brain with other regions. From what we know of the functions of the and the areas having to do with the association of this part of the frontal lobes, and of the mental differences between the races, Bean concludes that the lower mental faculties of the negro, such as small, sight, handicraftmanship, body-sense and melody, are well developed, but in the higher faculties, self-control, will power, ethical and esthetic senses and reason the negro falls considerably behind the Caucasian.—Exchange.

MULTIPLE CHANCRE.

A. F. Buchler states that while the initial lesion of syphilis is generally single, in a goodly proportion of cases it is found to be multiple. The results of the writer's investigations show that in the two hundred and seventy-three cases of initial lesion of syphilis recorded in recent years, thirty-three, or a proportion of more than twelve per cent were of the multiple form. Of these thirty-three cases, in twenty-five there were two lesions, in six there were three, and in two there were five.

The multiple lesion, according to the writer, was either purely genital, purely perigenital, or purely extragenital in location. In the first group there were thirty cases, in the second one, while two lesions were extragenital in position. Numerous well-attested examples of combinations of these groups have been recorded. As to the mode of evolution of the multiple lesion, the histories here reported are incomplete. However, the development of the chancres in most of the cases was said to be synchronous. In a number of instances the evolution was successive The interval between the appearance of the first and the successive lesion or lesions, with the exception of one case, never exceeded a week. The writer believes that in the negro the dual chancre is the rule.

AS MR. DOOLEY MIGHT SEE IT.

"Oi say," said Mr. Hennessey, "hev ye heard of th' case of noomoney all th' doctors b' tellin' about in th' Medical Worruld?"

"Oi hev," says Mr. Dooley, "an' mind ye besides th' noomoney he had th' Statues Presents, whativer that is, with 'is spootum all flyin t' paces like batter.

"Perhaps ye mind, Hennessey, when 'Oi had th' noomoney so bad last winter they'd prop me up in bed to breathe, me chist as tight as a drum, a coffin turrible, an' raisin' the dirtiest lookin' spootum, me heart a goin' boomtyboomp an' me a breathin' like the piston on th' Empire State Express.

"Thin in comes me old doc. and fixes me up some digy talus an' a pull at the bottle the old woman kapes 'n th' cupboard, then he phlastered me chist with some quare lookin' stuff called Aunty Plogistine, an'tho' Oi never knew befor' Oi had such a relation, she pulled the ache all out of me side; an' thin he fixed up the d'rndst mess of tartarie meltic an' surrup of pin feathers, squills or some such thing, an' Hennessey, ye should have seen th' chist ful of spootum 'Oi spooted.

"Whin th' praste cum th' next day he was tellin' me they'd cheated him out ov a job by poompin me full of oxy gin. W'u'd ye belave it, Hennessey, 'Oi never remimber drinkin th' stuff at all, an' thry as Oi' w'u'd 'Oi could'nt git th' taist ov it in me mouth. 'Oi'll never forgiv' them for not waking me up before 'Oi took it."—Ira F. Thompson, M. D., in The Medical World.

THE MAKING AND DRESSING OF WOUNDS.

Miles F. Porter declares that wounds should be as small as may be compatible with accurate, reasonably rapid work. He concludes his paper with the following statements: Unwise efforts to produce asepsis may cause more harm than the bacteria against which they are directed. The surgeon's attitude toward nature should be that of a modest cup-bearer, not that of a usurper. Sutures, redressings, and drains are, at best, necessary surgical evils; hence, all sutures should be discarded in favor of the bandage and adhesive plaster when these can be made to serve the same purpose, but when the use of sutures is imperative, then (a) buried absorbable sutures should be preferred; buried nonabsorbable temporary sutures should be the second choice; through-and-through sutures should be used only on compulsion, and buried permanent sutures should be discarded except in work on the hollow abdominal viscera; (b) the physician's aim should be to do the first dressing so that it will be the only one needed until healing is accomplished, and, when this is impossible, efforts should be directed toward preventing the necessity of frequent dressing; (c) when in doubt, the physician should not drain, but, if drainage is imperative, it should be adequate without being harmful, kept up while it is needed, and discarded so soon as it has fulfilled its mission.

THE USE OF NAUHEIM BATHS FOR THE FAILING HEART OF ACUTE INFECTIOUS DISEASES, ESPECIALLY IN PNEUMONIA; WITH STUDIES OF THE BLOOD-PRESSURE.

Philip King Brown says that under the immediate influence of Nauheim baths for chronic heart troubles there is a slowing of the respiration, a slowing in the heart rate, an increase in the volume of blood in the peripheral arteries, with a corresponding increase in arterial tension, and in the amount of urine eliminated. The writer has studied the effects of these baths on patients who were suffering from pneumonia. The pulse, respiration, temperature, and blood-pressure were taken before the bath. A full-strength bath was given at once. In

practically every instance there was a lessening in the pulse and respiration rate, and a rise in the blood-pressure. In a few cases the effect of various drugs on the blood-pressure was compared with the effect of the baths. In every instance the average blood-pressure was higher and better sustained on the days when baths were given than on the days when drugs were given. The writer believes that the supplemental use of drugs is not to be neglected.

PERNICIOUS EFFECTS OF ALTERNATING CURRENTS OF HIGH VOLTAGE.

Frederick H. Millener has recently made careful investigations in twenty-four cases of individuals suffering from the pernicious influence of the alternating current, especially when of high voltage. He calls attention to the well-known fact of the souring of milk immediately after a thunderstorm. In dairies in which separator machines are used the direct current is invariably employed because souring of the milk does not occur when this is used instead of the alternating current. The writer describes a patient who worked in one of the power plants. These plants are kept scrupulously clean, but the patient in a short time had lost his appetite, his face and hands had become almost chalky white, and his condition was becoming serious. The writer then asks what this mysterious force is which flows through the atmosphere. The other patients whom he has examined show symptoms similar to those here described. He believes that the condition is due to the effect of the alternating current of high voltage. He presents this problem, the solution of which he cannot predict. If a man thus disturbed should apply for life insurance he would be put in the substandard list. This problem is sufficient to warrant further study and investigation.

THE RELATION BETWEEN TONSILLITIS AND ACUTE ARTICULAR RHEUMATISM; WITH PARTICULAR REFERENCE TO THE PROPHYLAXIS OF POSTANGINAL RHEUMATISM.

Charles F. Kieffer has studied the retained records of Fort Russell for a period of thirty-eight years. These records show 2,275 cases, diag-

nosed as acute tonsillitis. In the same time there were 1,293 cases diagnosed as acute articular rheumatism. The records seem to indicate that the epidemic or infectious form of tonsillitis is followed in a large proportion of cases by rheumatism. In these records 276 cases of articular rheumatism were preceded by tonsillitis, a proportion of 21.3 per cent. The extreme incubation period varied between three days and thirty days, with an average of twenty-four days. The writer has had excellent results in the prophylactic treatment of postanginal rheumatism. On admission, the patient is given a full mercurial purge; the throat is then gargled with a saturated solution of sodium bicarbonate. Then finely-powdered acetyl-salicylic acid is rather firmly applied to the tonsil with a cotton-tipped wooden probe. Applications are made thrice daily. In the series of patients treated in this way not one case of rheumatism developed.

THE AMERICAN ABORIGINES FROM A HYGIENIC STANDPOINT.

A. L. Benedict presents an interesting study of the early history of the Iroquois and the Confederated Five Nations. They were not nomadic and not pastoral. Most of them lived jointly by hunting, fishing, and the cultivation of some of the more common vegetables. The degree to which vegetable food was used varied greatly according to local customs, soil, fertility, and the state of peace or war. Tobacco was obtainable only by barter and in small quantities. Willow bark was smoked to some extent, but smoking was not common. Alcoholic drinks were practically unknown until introduced by the whites. Semi-starvation alternated with gourmandizing. Almost all animal food was eaten well cooked. As a rule, permanent dwellings, as we understand the term, were not used. Small communities existed, but their location was changed from time to time, according to the need for firewood. Whenever a village was destroyed by fire, war, or any epidemic occurred, the site was permanently abandoned. As a rule these Indians manifested a considerable practical knowledge of sanitary science. Their villages were well located with reference to sandy soil, good drainage,

good brooks for fishing, etc. Burial places were placed at a safe distance, and not more than twenty skeletons have been found at any one place. These people were not prolific. Few remains of small children have been found.

SCLEROSIS OF THE CORONARY ARTERIES.

Harlow Brooks presents the results of a study of 270 cases noted in 1,000 consecutive autopsies. The disease may occur in comparative youth, being then amenable to treatment, and is not to be looked upon as a purely senile change. The average age of the author's cases has been about forty-five years. The abuse of alcohol appears to have been the most common exciting agent. The next most common cause is nephritis. Then comes syphilis. Other causes have been tuberculosis, cancer, diabetes, rheumatism, and myelitis. Overwork as a causative factor has probably been overestimated. The conditions producing gout and rheumatism may lead to coronary thickening. The most common type of the disease is that of an endarteritis in which proliferative alterations are introduced in the subepithelial layer of the intima, although certain cases appear to show primary pathological changes of the adventitia in the greatest degree. In the author's experience true arteritis is rare in the coronary arteries. The most frequent change in the heart muscle was fatty degeneration. All the 270 cases except fifteen showed lesions of the myocardium visible to the unaided eye. Brown atrophy was noted in sixty-four; fibrosis was found in twenty-four; hypertrophy was noted in thirty-five; actual dilatation demonstrable on post mortem was presented in twenty. The author discusses the symptoms of the disease and passes on to consider treatment. In early cases, when the condition may be presumed to be present, though not absolutely demonstrable, hygienic measures are of great service. All mental and physical excesses must be avoided. Causative factors must be eliminated as far as possible. Diet must be regulated for each individual case. In the advanced cases which call for the use of medicinal remedies probably the best one at our command is the iodides. When vasodilatation with sedation is required strontium bromide is of

great service. Chloral is often satisfactory in this direction. When immediate vasodilatation is required amyl nitrite is the choice. When the myocardium begins to degenerate drugs of the digitalis type are indicated. They must be used cautiously, however, or there may be a danger of fatal arterial spasm. When rapid heart action is present, rest in bed, morphine, and the icebag become imperative. Rest, however, may in some cases be enforced to an injurious degree.

INDICATIONS FOR SURGICAL INTERVENTION IN DISEASE OF THE STOMACH.

J. A. Blake divides operations on the stomach into three cases: First, repairs of wounds and perforations; second, improvement of drainage; and third, partial excision. In the first class surgical intervention is immediately indicated. In the second class the only conditions that can be helped are those which interfere with the normal drainage of the stomach. Such are pyloric obstruction, intermediate obstruction, or hour-glass stomach and ulcer. If there is evidence of pyloric obstruction we should not wait for evidence of a tumor, diminished hydrochloric acid, or dilatation of the organ. Hour-glass contraction always requires surgical intervention. In ulcers we may have acute or chronic conditions. In general the former call for medical and the latter for surgical aid, but we must be careful to understand just what is meant by these terms. Perhaps the designations of "early" and "late" would be better. Pyloric ulcers may be excised or treated by gastroenterostomy while cardiac ulcers must be excised. In the third class of cases the author states that when the pylorus with only the adjacent portions of the stomach and duodenum is removed, the operation is known as pylorectomy, while partial gastrectomy usually infers the removal of the pylorus with a considerable amount of the stomach. When only a small part of the stomach wall, such as an ulcer, is removed the term excision is employed. Carcinoma is the main indication for pylorectomy and partial gastrectomy, but not infrequently the pylorus, with the adjacent portion of the stomach, should be removed for ulcers, particularly when large or multiple; in fact, as has already

been stated, on account of the possibility of malignant degeneration, the excision of ulcers when practicable is always indicated. In cancer of the stomach there is no question as to the propriety of operating, unless we feel certain that it has advanced so far that there is no hope of good even from a palliative operation such as gastroenterostomy. The author then discusses points of differential diagnosis and shows by collated statistics that the mortality of these extensive operations is steadily lessening. He does not think that we should refuse operation in any case in which there is a chance for benefit, particularly when stomach drainage is being interfered with.

THE DANGERS OF THE X-RAY.

D. L. Edsall's study of this subject during the past eighteen months has shown that the rays have effects on metabolism, in some instances most violent, occurring even in normal individuals, and that these are apparently present whenever a general influence is clinically observable. These metabolic changes are due largely, if not entirely, he thinks, to tissue destruction as shown by a relatively large output of uric acid, purin bases, and phosphates, indicating the excess of nucleoproteid destruction. Histologic studies by Warthin and others show that the organs most affected are the bone marrow, spleen, and lymphoid tissues. Edsall says that the effects of a single dose may be more severe than those of a similar dose of any other therapeutic agent with which he is acquainted, and may be either very useful clinically or so dangerously violent as to hasten death, or even to cause it where it might otherwise have been avoided. He has known of two deaths from this cause. He thinks we will have to recast our views somewhat; instead of considering the xray as an agent only secondarily and somewhat distantly harmful, we should recognize in it an agent as effective as a powerful drug, and one not to be used without good and sufficient reasons and with all needed precautions against its doing any possible harm. The x-ray specialist, moreover, should be fully informed as to all possible contraindications, so as to be able to employ reasonable caution in his applications. Edsall compares the x-ray to anesthetics, which no one thinks of recommending without due consideration of

their possible dangers in any particular case. He mentions two groups of disorders that seem to him to deserve more careful consideration in this connection than others. One of these is nephritis; the other includes patients suffering from any serious degree of toxemia. A possible third group includes patients with decided anemia, especially if combined with toxemia. He believes that there are decided therapeutic possibilities in the action on metabolism of the x-ray, but it must be used with a definite appreciation of its restrictions.

PNEUMONIA.

Lockbridge (*Cent. States Monitor*) in speaking of the diversity of opinion as to the treatment of pneumonia in the present age says it was not so with our forefathers. Then (50 years ago) it was believed that we had an inflammation to deal with and an antiphologistic treatment was instituted. The results were as good, if not better, than ours. Then bleeding, wet cups, antimony, veratrium, etc., were the remedies used. A resume of his ideas of treatment are given as follows: Venesection, if admissible; if not, aconite, spts, niter, syr. doveri, and spts. menderiri, with mustard to extreme rubefaction, muriate ammonia and heroin if cough is viscid and painful; quinine and strichnia if indicated by failing powers; emunctories especially skin and kidneys kept stimulated.

The only excuse I have to make for offering this medley is that I wish to furnish my mite toward establishing the truth of the following three propositions:

1. Pneumonia is not an opprobrium medici, but it can be arrested by a judicious plan of treatment, and even throttled if combated on the threshold.

2. We should have well in mind the date of onset, the course, the extent and the stage of the disease by a constant and careful interpretation of the physical signs.

3. Above all we should bear in mind that it is the destruction of the lung with the general wreck and ruin that are killing our patient; and not starvation for a few days and a reasonably bold treatment.

PREVENTION OF CANCER.

Keetley lays down the following rules for the prevention of cancer. 1. Sterilize the food. The majority of cancers attack the alimentary canal, and especially the parts where food and feces tarry. 2. The sufficient and regular toilet and protection of the nipples and of the genitalia. It is significant that these organs are especially often polluted by stale secretions and discharges, and are more frequently handled by their owners than any other part of the person usually covered by clothing. 3. Due care of the mouth and teeth. 4. The dressings of discharging malignant sores and tumors should be cured, and especially not to pollute either fingers or the underlinen. 5. Non-malignant sores and tumors should be cured, and especially not allowed to drift on if chronic. 6. Cancerous and doubtful tumors and ulcers should be excised promptly. 7. Abstinence should be practiced from alcohol, tobacco, and from foods which leave waste products, of which the kidneys, the bowels and the skin can not easily and thoroughly get rid and which thereby provoke and sustain the chronic inflammations and ulcers which so often pave the way for cancer. 8. Physical familiarity should be avoided, except with those who are nearest and dearest to us. 9. Much thought should be given, especially by mistresses and housekeepers, to the service as well as to the cooking of food, with a view to disease prevention. Special attention should be paid to the sterilization of milk and its products, cheese and butter.

WIVES INFECTED WITH SYPHILIS BY THEIR HUSBANDS.

Fournier states that one-fifth of all the syphilitic women whom he has had occasion to treat had been infected by their husbands, and in 218 out of 321 cases by husbands who were syphilitic at the time of their marriage. In 130 out of 151 cases the infection occurred during the first year of married life, and in all but 13, during the first six months. In 142 cases the syphilitic infection in the husband dated in 37 cases from a few weeks to a year; from one to two years in 31, and from two to three years in 30, that is to say, that two-thirds of the men married while they were still in an infecting stage of the disease. Fournier used to believe that three or four years' delay was suf-

ficient to guarantee against infection of the wife, but now he declares that four or five years are necessary, and he says that another quarter century of experience might lead him to lengthen the period still further. In 9 cases the syphilis was transmitted in the second year after the marriage; in 3 in the third year; in 3 in the fourth; in 2 in the fifth; in 3 in the sixth; in 2 in the seventh, and in 1 case each during the eighth and ninth year after marriage. This astonishingly tardy transmission of the disease, he says, confers a new physiognomy on syphilis, demonstrating a tardy secondary syphilis. Recent research has demonstrated that the secondary period is not always restricted to the first three years of the disease, but may develop, with typical secondary symptoms, at the fifth, eighth, tenth, fifteenth or twentieth year, or later still. This tardy secondary syphilis entails tardy secondary contagion if occasion offers.

WHAT MAY BE ACCOMPLISHED WITH APPARENTLY HOPELESS CASES OF TUBERCULOSIS.

Ten cases are reported by S. G. Bonney. They go to demonstrate the following propositions: (1) They are selected merely to illustrate the possibility of arrest in far-advanced cases. (2) The cases here described represent not simply what might be regarded as decidedly unfavorable cases, but were considered without exception, by other physicians as well as the author, as being utterly hopeless by virtue of every consideration which may ordinarily influence prognosis. (3) With the exception of the three cases, which are of very recent origin, the remaining seven have not simply undergone improvement with the ultimate outcome as yet uncertain, but have actually experienced a complete arrest of the tuberculous trouble, with entire absence of physical signs, sputum, and bacilli, with a complete restoration to former usefulness and activity. (4) The necessity for the practice of strict economy has been no insuperable barrier to the acquirement of complete arrest in a suitable climate and under proper regime. (5) No claim is made that the results obtained were entirely referable to climatic influences. It is contended, however, that such results in equally

desperate cases are impossible of attainment in what may be regarded as relatively unfavorable climates, no matter how perfect the regime. (6) No special methods of treatment were employed other than those familiar to every physician of experience in the management of pulmonary tuberculosis. (7) No credit for results obtained is assumed other than that which may relate to an unremitting personal attention to detail, according to the exigencies of the situation and an adaptation of means to ends at times somewhat radical. (7) No case is here reported that is not entirely subject to confirmation by the attending physicians whose names are not cited in the report.

MICHIGAN STATE LAW.

Providing for the Giving of Elementary Sanitary Instruction in Public Schools.

Michigan Public Acts, 1895. Chapter 146. *An Act to Provide for Teaching in the Public Schools the Modes by which the dangerous communicable diseases are spread, and the Best Methods for the Restriction and Prevention of such Diseases.*

Sec. 1. The People of the State of Michigan enact that there shall be taught in every year in every public school in Michigan the principle modes by which each of the dangerous communicable disease are spread, and the best methods for the restriction and prevention of each of such diseases. The State Board of Health shall annually send to the public school superintendents and teachers throughout the State printed data and statements which shall enable them to comply with this act. School boards are hereby required to direct such superintendents and teachers to give oral and blackboard instruction, using the data and statements supplied by the State Board of Health.

Sec. 2. Neglect or refusal on the part of any superintendent or teacher to comply with the provisions of this law shall be considered a sufficient cause for dismissal from the school by the school board. Any school board wilfully neglecting or refusing to comply with any of the provisions of this act, shall be subject to fine the same as for neglect of any other duty pertaining to their office. This act shall apply

to all schools in the State, including schools in cities or villages, whether incorporated under special charter or under the general laws.

Approved May 16, 1895.

THE EFFECTS OF PERICARDITIS ON THE HEART.

N. S. Davis reviews the symptoms and lesions of pericarditis which are liable to be unrecognized because they are secondary in most cases to infections producing other symptoms that engross the practitioner's attention, especially when there is not much serous effusion. The myocardium is not apt to be seriously involved in acute or fibrinous forms of pericarditis, save in cases where the pericardial inflammation has complicated an already enfeebling condition. The effects of adhesions have no characteristic symptoms and rarely interfere with the functions of the heart to serious or even noticeable extent. The most trustworthy symptom is the unchanging shape of the area of precordial dullness during inspiration and expiration, which must exist when a pericarditis fastens the heart to the anterior wall of the chest. Adhesions are not usually very dangerous except in enfeebled conditions or after acute illness interfering with compensation. In most cases pericarditis is not fatal. From 50 to 75 per cent. of patients are estimated as recovering. Rheumatic pericarditis, as compared with that from other infections, is benign. Purulent and hemorrhagic pericarditis, unless recognized and successfully treated, is almost always fatal. A rapidly developed effusion is dangerous, but aspiration or treatment may produce recovery or a prolongation of life. A large slowly developed effusion is not threatening or immediately dangerous, and a small effusion is of no more gravity than fibrinous inflammation. About one-third of all cases are serofibrinous, about one-sixth are hemorrhagic or purulent, about one-twelfth tuberculous, and in an approximate number there is total adhesions, but in one-third there are partial adhesions. The condition of the heart muscle largely influences the prognosis. The chance of prolonging life is slight in cases of chronic alcoholism and the cachexias of cancer, Bright's disease, and tuberculosis. In these it is usually due to a terminal infection and is often the direct cause of death. It is also a much more serious complication with pneumonia than tuberculosis, and is a very grave complication with sepsis. Naturally, it is most dangerous at the extreme periods of life.

THE PURE FOOD LAW.

A national pure food law has successfully passed both houses of Congress at Washington. Bitter opposition marked its progress, but its passage was facilitated by the recent exposition of the methods of the meat packers and perhaps by its being coupled with the drug, patent medicine and liquor legislative provisions. It is a matter for congratulation that the law has been passed. Every physician has long been aware of the need of more stringent legislation regarding the manufacture and sale of pure drugs, patent medicines and fermented liquors and regards the passage of the law as a victory of no ordinary sort.

Considerable hardship will be entailed, at the time of its taking effect, upon many manufacturers of food products who desire to comply with every provision of the law, at the same time aiming to increase the sale and broaden the field for the demand of their products. Manufacturers of canned foods have found that the rough handling and variations of climate to which their products were necessarily subjected in shipping required some method of preserving more potent than was needed when used in the immediate locality where they were made. For this purpose, as physicians have been generally aware, the salicylates and benzoates of sodium, as preservatives, were resorted to. Varying quantities were used according to the treatment which the contents of the packages were expected to receive. Catsups, for example, which must stand uncorked at varying temperatures and varying periods, and in climates of warm as well as cold regions, had to be treated to considerable amounts of preservative in order to remain fit for use.

Tins of canned vegetables required less, since their entire contents are used as soon as opened. For improving the appearance of these however, chemicals have been freely used. Jams and jellies which are not sealed hermetically at the factory, and which are often subjected to a deal of rough handling before they have reached the consumer, were believed to require some preservative.

All these and various other food products must now, under the new law, be labeled with the proportion of preservative contained therein.

To many consumers the fact that any artificial preservative is used will come as a surprise, and it will not likely appear of moment whether the amount used is large or small.

The manufacturers anticipate a falling off of their sales when the law goes into effect.

Much will depend on the attitude of the practitioner of medicine as to how far the decrease of sale of these food products will extend and

how long it will last. The individual opinion of physicians will no doubt vary on this point, and probably their views concerning the different food preparations will be influenced by the amount of preservative which a given product contains.

THE TORONTO MEETING OF THE BRITISH MEDICAL ASSOCIATION.

By Horace M. Simmons, M.D.

In the presence of a common foe all mankind is united.

This was the clarion note which went forth from the new Convocation Hall as the distinguished medical representatives from all parts of the British domain assembled in the seventy-fourth annual meeting of the British Medical Association, the largest and most influential medical organization in the world. The classic inaugural was delivered by Richard Andrews Reeve, B.A., M.D.,LL.D., Dean of the Faculty of Medicine, University of Toronto, in the presence of a large and representative audience. Only once before had the imperial congress crossed the seas to convene outside the British Isles, when it met in Montreal synchronously with the Advancement of Science, at Toronto. These events occurred in the year of the celebration of Queen Victoria's diamond Jubilee. The feeling of imperial sympathy already evoked was thereby extensively promoted.

Twenty-two hundred delegates and visitors registered at the Toronto meeting. This number had been exceeded only once before in the history of the Association, in London, in 1895, where the attendance was 2,800. Besides those from the British Isles, India, Autralia, South Africa, New Zealand, and Tasmania were represented, one delegate having travelled a distance of 10,000 miles. About five hundred registered from the Provinces and as many more from the States. The scientific work embraced thirteen sections. An extensive tuberculosis exhibit, a pathological museum and other instructive features, were arranged in the different University buildings, which were perfectly adapted for the purpose. The pharmaceutical exhibit was one of the finest we have ever seen, if not the most extensive.

The next meeting of the Association will be held at Exeter, England, in August, 1907. The Association was organized in 1832 under the name of the "Provincial Medical and Surgical Association," with fifty members, and reorganized in 1856. Its present membership is 19,000. The organization embraces sixty-eight branches. The next president will be Henry Davy, M.D., M.B., F.R.C.P., London, Physician Devon and Exeter Hospital. The past president was Dr. George C. Franklin, of Leicester, England.

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